S. HRG. 107–760

# NOMINATIONS OF ROBERT H. ROSWELL, M.D., TO BE UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS AND DANIEL L. COOPER, TO BE THE UNDER SECRETARY FOR VETERANS BENEFITS, DEPARTMENT OF VETERANS AFFAIRS

## HEARING

BEFORE THE

## COMMITTEE ON VETERANS' AFFAIRS
## UNITED STATES SENATE

ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

MARCH 14, 2002

Printed for the use of the Committee on Veterans' Affairs

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# C O N T E N T S

MARCH 14, 2002

## SENATORS



## WITNESSES



## APPENDIX

# NOMINATIONS OF ROBERT H. ROSWELL, M.D., TO BE UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS AND DANIEL L. COOPER, TO BE THE UNDER SECRETARY FOR VETERANS BENEFITS, DEPARTMENT OF VETERANS AFFAIRS

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**THURSDAY, MARCH 14, 2002**

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
*Washington, DC.*

The committee met, pursuant to notice, at 2:26 p.m., in room 418, Russell Senate Office Building, Hon. John D. Rockefeller IV (chairman of the committee) presiding.

Present: Senators Rockefeller, Graham, and Nelson of Nebraska.

Chairman ROCKEFELLER. Good afternoon.

Would it be more efficient if we allowed Senators Graham and Nelson to go ahead and do the introductions now? Then we can make our opening statements.

Senator NELSON OF FLORIDA. That would be great.

Chairman ROCKEFELLER. Then that is what I think we should do, if that is all right with you, Senator.

## STATEMENT OF HON. BOB GRAHAM, U.S. SENATOR FROM FLORIDA

Senator GRAHAM. Mr. Chairman, I appreciate your courtesy to my colleague and myself. We are here on behalf of the nomination of Dr. Robert Roswell to be Under Secretary for Veterans Health.

I have had the good fortune of knowing Dr. Roswell for a number of years and have observed at close range the outstanding service that he has provided to the VISN, which includes Florida, Southern Georgia, Puerto Rico, and the Virgin Islands. It doesn't quite make it to West Virginia——

Chairman ROCKEFELLER. My life is filled with disappointments and I am certain that has been one of Dr. Roswell's. But now, if confirmed in his new position, he will finally get to West Virginia.

Senator GRAHAM. In his position at VISN 8, which is referred to as the VA Sunshine Health Care Network, a very appropriate title, he has had health care responsibility for over 410,000 veterans. It is the largest VISN in the country. His philosophy has been always do what is right for the veteran. He has been very oriented toward service to the veteran.

In his 6 years in leadership in VISN 8 he has accomplished a number of outstanding gains for the benefit of veterans. I will just mention a few of them. He has seen first a tremendous growth and expansion within the VISN. He also has been able to meet this growth and expansion in a very cost-effective way.

Of the 22 VISN's, VISN 8 ranks second in terms of its efficiency in the use of VA funds for health care services.

He also has seen a large increase in the number of users. There has been a 17-percent increase in the number of veterans in VISN 8. He has, in addition to his duties in VISN 8, has served as the Executive Director of the Persian Gulf Veterans Coordinating Board from 1994 to 1999.

In that capacity he coordinated Persian Gulf veterans and activities as they related to medical care and research and disability compensation on a national basis between the Department of Defense, Health and Human Services, and the Veterans Administration.

Mr. Chairman, I would like to file the balance of my statement in full in the record, but just conclude by saying that Dr. Roswell's qualifications in my judgment make him an ideal candidate for this important position. He is admired and eminently qualified to serve as the Under Secretary of Health for the VA.

I appreciate this committee's expedited consideration of Dr. Roswell's nomination and I look forward to working with you to fill this important current vacancy in the Department of Veterans Affairs.

[The prepared statement of Senator Graham follows:]

PREPARED STATEMENT OF HON. BOB GRAHAM, U.S. SENATOR FROM FLORIDA

Mr. Chairman, thank you for scheduling this hearing. I would also like to thank the committee for its attention to the nominee—a man who has devoted his career to serving our nation's Veterans.

It is my pleasure to welcome and introduce Dr. Robert Roswell. My colleague and good friend, Senator Nelson will also be giving some remarks and in an effort not to be repetitive, my remarks will concentrate on his professional experience and numerous accomplishments.

I have known Dr. Roswell since 1995, when he was appointed as Network Director of the VA Sunshine Healthcare Network (VISN 8). As director, he has oversight for the healthcare operation of the largest Veterans Network in the Department of Veterans Affairs. The Network provides health care to over 410,000 veterans throughout Florida, Puerto Rico, southern Georgia and the U.S. Virgin Islands.

In addition to his duties as Network Director of VISN 8, Dr. Roswell also served as Executive Director of the Persian Gulf Veterans Coordinating Board from 1994 to 1999. In this capacity, he coordinated Persian Gulf veterans programs and activities related to medical care, research and disability compensation between the DoD, Health and Human Services, and Veterans Affairs.

Dr. Roswell has also remained directly engaged in medicine. He serves as a Colonel in the Medical Corps, U.S. Army Reserve and during his tenure as Network Director was also Commander of the Army's 73rd Field Hospital, St. Petersburg, FL.

Dr. Roswell's philosophy for providing care to our Nation's veterans is summed up in a simple phrase; "Always do what is right for the veteran." What he has accomplished over the past six years for VISN 8 clearly indicates that both providing the highest quality of care in a cost effective way, and maintaining patient satisfaction has been his utmost priority. Under his leadership, VISN 8 has seen tremendous growth and expansion. Additionally, VISN 8's cost per veteran continues to decline and it is consistently one of the most cost efficient VISNs, ranking second out of the 22 VISNs. Veterans in VISN 8 have been well served as a result of Dr. Roswell's efforts as Network Director.

One of the major challenges facing the Veterans Administration is timely access to quality health care. All of the VISN's have seen a huge increase in new users,

Florida handling the largest number of new users, receiving over 17% of all new enrollees in 2001. As Florida's VISN Director, Dr. Roswell is well aware of this challenge and is committed to work to improve the delivery of health care.

Dr. Roswell has had a distinguished career in the Department of Veterans Affairs and has been recognized at the national level. Some of the awards he has received include: the VA Secretary's Commendation, Department of Veterans Affairs Superior Performance Awards, VA's Meritorious Service Award, the AMSUS John D. Chase Award for Physician Executive Excellence. He has also been recognized by the Senior Executives Association Professional Development League with an Executive Achievement Award.

Mr. Chairman, Dr. Roswell's qualifications make him the ideal candidate for this important position. Dr. Roswell is an admired and eminently qualified candidate to serve as Undersecretary of Health for the VA.

I appreciate the Committee's consideration of Dr. Roswell's nomination and look forward to working with you to fill this important vacancy in the Department of Veterans Affairs.

Chairman ROCKEFELLER. Thank you, Senator Graham.

Senator Nelson.

**STATEMENT OF HON. BILL NELSON, U.S. SENATOR FROM FLORIDA**

Senator NELSON OF FLORIDA. Thank you, Mr. Chairman. I would echo the comments of my colleague. We are very fortunate to have such a professional from the State of Florida.

I would just add that he also has the personal touch. As I was looking into his background I noticed the commentary from one 100 percent disabled veteran who had gone through major surgery at one of our VA hospitals. His comment was that the good doctor took the time to call after the surgery to see how he was. It is that kind of caring and compassion, that personal touch, that is so needed as we confront not only the problems and challenges of veterans, but seeing that they get the deserved recognition and due that they are owed by this country.

That is why I am here on behalf of Dr. Bob Roswell.

Chairman ROCKEFELLER. Well, thank you, Senator, very much. I appreciate your presence. We are honored.

We will now go ahead with our statements. We need to swear both of you in, then have your statements, and then we will have questions.

As has been made clear, we are meeting in formal session to consider the nominations of Daniel L. Cooper to be Under Secretary for Benefits and also Dr. Robert Roswell to be Under Secretary for Health. These are two monumental positions. It is very unusual to be confirming two people that have so much responsibility between them.

To occupy those two positions means that you will be affecting the VA's future, or you will not. But you have the opportunity to do that. If confirmed, your actions will shape the delivery of health care and benefits and probably because of where we are right now in our country, for decades to come.

Both of you have shown your commitment to this Nation through your distinguished careers, so I know that I don't have to impress upon you the importance of the leadership roles for which both of you are up for confirmation.

We look to both of you to find the path which has always been out there for VA but which has never been fully, in my judgment, realized.

Dr. Roswell, if you are confirmed you will take over the reins of the VA health care system at a very, very difficult time. You will have many conversations with me about long-term care and the fact that it has not happened.

Clinics and hospitals have long waiting lists. Providers are overworked. Nurses are in short supply and will become more so. Veterans, at least many of them, are frustrated. Members of the VA Appropriations Subcommittee are frustrated, as well, and blame this committee and the VA Committee on the House side for the budget problems.

I for one do not apologize for the new benefits that we have enacted. I don't like having Appropriations trying to overtake our responsibility, and I will fight to preserve the integrity of this committee.

We have expanded the benefits package. We have improved the system, and it is those very changes that have caused many veterans to seek VA care for the first time. So, there is good news. There are more veterans coming, not less.

Instead of pointing fingers and engaging in an effort to avoid the challenges we all face, I for one, and I know every member of this committee—all of us pledge to work with our colleagues to make sure that sufficient funds are directed to the VA. We have to do our part.

If you are confirmed, it will fall on your shoulders, Dr. Roswell, to manage the health care system. On the benefits side, it may be fair to say that I have never seen the system in as difficult a situation as it is today.

While the VA has a tremendously dedicated work force that cares deeply for the veterans that it serves. It has been hampered by an institutional inertia.

There is a group in any agency, particular one which is as large as the VA, which just doesn't want to see things change. The question is: How do you make change. That will be your great challenge.

You have the consequences of an aging work force, an ever-increasing level of work, the demands of the veterans, the complexity imposed by changes in laws that we make.

So, Mr. Cooper, if confirmed, one of the difficulties you will face will be implementing the plan set forth by the task force that you chair. I don't know whether the direction proposed by the task force is better than the one the VA has been pursuing, but I do know that any significant change could be very difficult to carry out.

I also know, historically, that VA has a tendency to propose great plans and then somehow the status quo continues. VA in not unique in that. So, I urge you to resist the tremendous pressures from all around, and sometimes even for those of us in the Congress, to only focusing on reducing the backlog or the number of days it takes to process an original claim.

Please don't lose sight of the big picture. No part of the system can be ignored. I will say that to both of you: All parts are important. Above all, there must be accuracy in decisionmaking and confidence veterans must have in the quality of those decisions.

Cutting corners, even the mere perception of cutting corners, will lead to appeals. These will not only burden the VA, but they are enormously detrimental to the veterans who await the outcome of those appeals.

I am not aware of the order of arrival, so I will call on Senator Graham.

Senator GRAHAM. Mr. Chairman, I have no opening statement.

Chairman ROCKEFELLER. Senator Nelson.

Senator NELSON of Nebraska. Well, my opening statement is more of a question. After the chairman's description of the jobs, my question is: Do you still want the jobs?

Chairman ROCKEFELLER. Yes, they do.

Senator NELSON of Nebraska. I will forego an opening statement. Thank you.

Chairman ROCKEFELLER. OK. Let me say for the record that both nominees have completed the committee questionnaire for Presidential nominees. They have responded to my pre-hearing questions, all of which will appear in the hearing record.

Also included will be a letter from the Office of Government Ethics acknowledging that each is in compliance with laws and regulations governing conflicts of interest.

As chairman of the committee, I will review both nominee's FBI records and then we will seek committee action of their nominations. Senator Specter, of course, will join me in doing that.

So, I would ask you now, if you would stand and raise your right hand so that I can administer the required oath.

Do you both swear and affirm that the testimony that you will give at this hearing and any written answers or statements you provide in connection with this hearing will be the truth, the whole truth and nothing but the truth?

Dr. ROSWELL. I do.

Mr. COOPER. I do.

Chairman ROCKEFELLER. Please be seated. We are very interested in what you have to say.

**STATEMENT OF ROBERT H. ROSWELL, M.D., NOMINATED TO BE UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS**

Dr. ROSWELL. Mr. Chairman and committee members, especially Senator Graham who I thank for that very gracious introduction, it is my distinct honor and pleasure to appear before you today to discuss the future of VA health care.

Under the visionary and capable leadership of Dr. Ken Kizer and Dr. Tom Garthwaite the Veterans Health Administration has undergone a remarkable transformation. Health care delivery has been shifted from costly inpatient settings to an outpatient based primary care delivery model focused on prevention and health maintenance.

Quality has risen from questionable to exceptional and for the first time in many years we face a burgeoning demand for care that threatens to exceed the finite resources within VA.

I believe that it is important to continue this transformation, safeguarding the quality of the care that is at the vary heart of the system, while continuing to move the focus of care from the hos-

pital to the outpatient clinic to the community and into the homes of veterans. But in so doing, we must also plan for the future needs of veterans and enhance our ability to respond to a growing demand for VA care.

We must move quickly to assure that the long-term care and end-of-life needs of World War II veterans will be met in ways that provide the care and dignity these veterans have earned by their service and the functional independent and emotional support they so desperately seek.

We must learn from our experience in treating Vietnam and Gulf War veterans and recognize that whenever we send men and women into harm's way there will be health care consequences that VA must be prepared to face.

Although the exposures our military may face and the illnesses that they develop may vary, the risk is certain and VA is uniquely situated to respond to these needs.

We must also improve the capture and utilization of all resources available to support the veterans health care system, including medical care cost recovery from private insurance companies and we must enhance our business expertise in order to strengthen our efforts to meet the growing demand for VA care.

Much of VA's progress over the last few years can be traced to VHA's reorganization into 21 VISN's or regions around the country. This coupled with the introduction of a performance measurement system has greatly transformed VA. However, the time has come to minimize variation across the 21 Veterans Integrations Service Networks within VHA and maximize our performance across the entire system.

I deeply believe that this can be accomplished by the introduction of a comprehensive strategic planning process with involvement with all key stakeholders, careful alignment of performance measurement systems with VA's strategic goals and a cross-cutting management and oversight system for key functional areas across all of the networks.

Mr. Chairman, if confirmed I look forward to continuing a productive dialog with you and the committee members to assure a vital and responsive health care system for generations of veterans yet to come.

Thank you.

[The prepared statement of Dr. Roswell follows:]

PREPARED STATEMENT OF ROBERT H. ROSWELL, M.D., NOMINATED TO BE UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee:

I am pleased to appear before you today as President Bush's nominee to lead the Veterans Health Administration. For the past twenty years I have devoted my professional life to serving the needs of veterans in a variety of capacities, and I am honored to be considered by you for this position.

Over the past six years, under the visionary and capable leadership of Dr. Ken Kizer and Dr. Thomas Garthwaite, the Veterans Health Administration has undergone a remarkable transformation. Healthcare delivery has been shifted from costly inpatient settings to an outpatient-based primary care delivery model focused on prevention and health maintenance. Quality has risen from questionable to industry leading in many respects; and for the first time in many years we face a burgeoning demand for care that threatens to exceed finite resources within VHA.

I believe that it is important to continue this transformation, safeguarding the quality of care that is at the very heart of the system, while continuing to move

the locus of care from the hospital to the outpatient clinic, to the community, and into the homes of veterans. But we must also plan for the future needs of veterans and enhance our ability to respond to a growing demand for VA care.

We must move quickly to assure that the long-term care and end-of-life needs of World War II veterans will be met in ways that provide the care and dignity these veterans have earned, and the functional independence and emotional support they seek. And we must find ways to meet these needs without irrevocably committing our physical infrastructure in a manner ill suited for the needs of those veterans who will come behind them.

I believe we must learn from our experience in treating Vietnam and Gulf War veterans, and recognize that whenever we send men and women into harm's way, there will be healthcare consequences that VA must be prepared to face. Although the exposures our military may face, and the illnesses they will develop may vary, the risk is certain and VA is uniquely situated to respond to their needs.

We must also improve the capture and utilization of all resources available to support the veterans healthcare system. Many of our patients have earned benefits from all three of our country's federal healthcare programs, yet sadly they still face substantial out-of-pocket expense to obtain the care they need. We must improve cost recovery efforts and enhance our business acumen to facilitate our efforts to meet a growing demand for VA care.

Much of VA's remarkable transformation over the last few years is rooted in the network structure put in place in 1996. This reorganization, coupled with the introduction of a performance measurement system, has led to substantial change across what some have characterized as 22 "innovation laboratories". However, others have expressed concerns over the regional variations in programs and services. The time has come to maximize performance and minimize variation across the 21 Veterans Integrated Service Networks within the Veterans Health Administration.

I believe this can be accomplished by the introduction of a comprehensive strategic planning process with involvement of all key stakeholders, careful alignment of the performance measurement system with VA strategic goals, and a cross-cutting management and oversight system for key functional areas across all networks.

Mr. Chairman, if confirmed, I look forward to a continuing and productive dialogue with you and Committee members, as well as other members of Congress as we work to assure a vital and responsive healthcare system for generations of veterans yet to come.

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UNITED STATES OFFICE OF GOVERNMENT ETHICS,
*Washington, DC, February 8, 2002.*

Hon. JOHN D. ROCKEFELLER IV,
*Chairman, Committee on Veterans' Affairs,*
*U.S. Senate,*
*Washington, DC.*

DEAR MR. CHAIRMAN: In accordance with the Ethics in Government Act of 1978, I enclose a copy of the financial disclosure report filed by Robert H. Roswell, who has been nominated by President Bush for the position of Under Secretary for Health, Department of Veterans Affairs.

We have reviewed the report and have also obtained advice from the Department of Veterans Affairs concerning any possible conflict in light of its functions and the nominee's proposed duties. Also enclosed is a letter December 21, 2001, from the Department's ethics official, outlining the steps Dr. Roswell will take to avoid conflicts of interest. Unless a specific date has been agreed to, the nominee must fully comply within three months of his confirmation date with the actions he agreed to take in his ethics agreement.

Based thereon, we believe that Dr. Roswell is in compliance with applicable laws and regulations governing conflicts of interest.

Sincerely,

AMY L. COMSTOCK,
*Director.*

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QUESTIONNAIRE FOR PRESIDENTIAL NOMINEES

PART I: ALL THE INFORMATION IN THIS PART WILL BE MADE PUBLIC

1. Name: Robert Roswell.
2. Address: 13528 Oak Run Court, Seminole, FL 33776.
3. Position to which nominated: VA Under Secretary for Health.

4. Date of Nomination: February 6, 2002.
5. Date of birth: August 13, 1949.
6. Place of birth: Bartlesville, OK.
7. Marital status: Married.
8. Full name of spouse: Cheryl Anne Roswell.
9. Names and ages of children: Sara Elizabeth Roswell, 13; Alexander Robert Roswell, 11; Ashley Rene Roswell, 8.
10. Education: Institution (including city, state), dates attended, degrees received, dates of degrees:
Oklahoma State Univ, Stillwater OK; 1967–1971; BS; 1971.
Univ of Oklahoma, Oklahoma City, OK; 1971–1975; M.D.; 1975.
Univ of Oklahoma Health Sciences Center; 1976–1978; Internal Medicine Residency.
Univ of Oklahoma Health Sciences Center; 1980–1982; Endocrinology Fellowship.
11. Honors and awards: List all scholarships, fellowships, honorary degrees, military medals, honorary society memberships, and any other special recognitions for outstanding service or achievement:
John D. Chase Award for Physician Executive Excellence, AMSUS, 1999.
Army Meritorious Service Medal, 2000.
Senior Executives' Association Professional Development Leagues Executive Excellence Award for Executive Achievement finalist.
Department Appreciation Award, Disabled American Veterans, 1999.
Vice President Al Gore's National Partnership for Reinventing Government Hammer Award, 2001.
12. Memberships: List all memberships and offices held in professional, fraternal, business, scholarly, civic, charitable, and other organizations for the last 5 years and other prior memberships or offices you consider relevant:
Assoc. of Military Surgeons of U.S.; Member; Current.
Persian Gulf Veterans Coordinating Board; Executive Director; 1994–1999.
Dept. of Environmental & Occupational Health, Univ. of South Florida, Tampa, FL; Professor; 1998–present.
American College of Physician Executives; Member; Current.
American Board of Internal Medicine; Diplomate; 1978.
National Board of Medical Examiners; Diplomate; 1976.
Alpha Omega Alpha Honor Medical Society; 1975.
13. Employment Record: List all employment (except military service) since your twenty-first birthday, including the title or description of job, name of employer, location of work, and inclusive dates of employment:
Network Director, Veterans Integrated Service Network #8, Dept, of Veterans Affairs, Bay Pines, FL (1995–Present).
Chief of Staff, Veterans Affairs Medical Center, Birmingham, AL (1993–1995).
Associate Deputy Chief Medical Director for Clinical Programs, Dept. of Veterans Affairs, Central Office, Washington, D. C. (1991–1993).
Chief of Staff, Veterans Affairs Medical Center, Oklahoma City, OK (1989–1991).
Acting Chief of Staff, Veterans Administration Medical Center, Dallas, TX (1988).
Acting Assoc. Chief of Staff for Ambulatory Care; Chief General Medicine Section, Veterans Administration Medical Center, Dallas, TX (1985–1986).
Associate Chief of Staff for Education; Senior Staff Physician, Endocrinology Section; Veterans Administration Medical Center, Dallas, TX (1984–1988).
Staff Physician, Oklahoma Memorial Hospital, Oklahoma City, OK (1982–1984).
Staff Physician, Martin Army Hospital, Fort Benning, Georgia (1978–1980).
14. Military Service: List all military service (including reserve components and National Guard or Air National Guard), with inclusive dates of service, rank, permanent duty stations and units of assignment, titles, descriptions of assignments, and type of discharge:
Colonel, US Army Reserve, Office of Domestic Healthcare Policy, Office of the Army Surgeon General (2002).
Colonel, Medical Corps, U.S. Army Reserve, Commander, 73rd Field Hospital, St. Petersburg, FL (1997–2000).
Colonel, Medical Corps, U.S. Army Reserve, 73rd Field Hospital, St. Petersburg, FL (1996–1997).
Colonel, Medical Corps, U.S. Army Reserve, 3345th U.S. Army Hospital, Birmingham, AL (1992–1996).
Lieutenant Colonel, Medical Corps, U.S. Army Reserve, Division Surgeon, 95th Division (Training), Midwest City, OK (1989–1991).
Lieutenant Colonel, Medical Corps, U.S. Army Reserve, Preventive Medicine Officer, 807th Medical Brigade, Seagoville, TX (1987–1989).

Major, Medical Corps, U.S. Army Reserve, Preventive Medicine Officer, 807th Medical Brigade, Seagoville, TX (1985–1987).

Major, Medical Corps, U.S. Army Reserve, 94th General Hospital, Dallas, TX (1984–1985).

Captain, Medical Corps, U.S. Army Reserve, 44th Evacuation Hospital, Oklahoma City, OK (1980–1984).

Captain, Medical Corps, Martin Army Hospital, Ft. Benning, GA (Active Duty 1978–1980).

15. Government experience: List any advisory, consultative, honorary, or other part-time service or positions with Federal, State, or local governments other than listed above:

None except as previously noted.

16. Published writings: List titles, publishers, and dates of books, articles, reports or other published materials you have written:

Roswell, R., Mullins, M., Weaver, T., Law, D., Mullins, D., Koenig, K., Boatright, C., Teeter, D., and Gray, E., Weapons of Mass Destruction: An Educational and Experiential Training Model for Healthcare Professionals. Presented at the Association of Military Surgeons of the U.S., Annual Meeting, 2000, Las Vegas, NV.

Roswell, R.H., Van Diepen, L.R., Jones, J.K., and Hicks, W.E., Adverse Drug Reactions Definitions, Diagnosis, and Management, 2001 Lancet 357;561.

Hyams, K. C., and Roswell, R.H., Resolving the Gulf War Syndrome Question, 1998 American Journal of Epidemiology 148;329–349.

Hyams, K. C., Wignall, F. S., and Roswell, R., War Syndromes and Their Evaluation: From the U.S. Civil War to the Persian Gulf War. 1996 Annals of Internal Medicine 125; 398–40.

Beach, P., Blank, R.R., Gerrity, T., Hyams, K.C., Mather, S., Mazzuchi, J.F., Murphy, F., Roswell. R., and Sphar, R.L., Coordinating Federal Efforts on Persian Gulf War Veterans, 1995 Federal Practioner 12:No. 12:9–15.

17. Political affiliations and activities

(a) List all memberships and offices held in and financial contributions and services rendered to any political party or election committee during the last 10 years: None.

(b) List all elective public offices for which you have been a candidate and the month and year of each election involved: None.

18. Future employment relationships

(a) State whether you will sever all connections with your present employer, business firm, association, or organization if you are confirmed by the Senate: Currently, I am a VA career employee.

(b) State whether you have any plans after completing Government service to resume employment, affiliation, or practice with your previous employer, business firm, association or organization: N/A.

(c) What commitments, if any, have been made to you for employment after you leave Federal service? None.

(d) (If appointed for a term of specified duration) Do you intend to serve the full term for which you have been appointed? Yes.

(e) (If appointed for indefinite period) Do you intend to serve until the next Presidential election? N/A.

19. Potential Conflicts of Interest

(a) Describe any financial arrangements, deferred compensation agreements, or other continuing financial, business, or professional dealings which you have with business associates, clients, or customers who will be affected by policies which you will influence in the position to which you have been nominated: None.

(b) List any investments, obligations, liabilities, or other financial relationships which constitute potential conflicts of interest with the position to which you have been nominated:

See attached schedule of listed securities.*

(c) Describe any business relationship, dealing, or financial transaction which you have had during the last 5 years, whether for yourself, on behalf of a client, or acting as an agent, that constitutes as potential conflict of interest with the position to which you have been nominated: None.

(d) Describe any lobbying activity during the past 10 years in which you have engaged for the purpose of directly or indirectly influencing the passage, defeat, or modification of any Federal legislation or for the purpose of affecting the administration and execution of Federal law or policy: None.

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*NOTE: The information referred to has been retained in the committee's files.

(e) Explain how you will resolve any potential conflicts of interest that may be disclosed by your responses to the above items. (Please provide a copy of any trust or other agreements involved.)

In consultation with the Office of Government Ethics, I will recuse myself from any procurement decision involving any of the companies in which I hold an equity position.

20. Testifying before the Congress

(a) Do you agree to appear and testify before any duly constituted committee of the Congress upon the request of such committee? Yes.

(b) Do you agree to provide such information as is requested by such a committee? Yes.

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RESPONSE TO WRITTEN PRE-HEARING QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO ROBERT H. ROSWELL, M.D.

*Question 1a.* Dr. Roswell, I have a series of questions relating to the current network structure. As a current VISN director and nominee for Under Secretary, you are uniquely situated to know how the current structure works for the network director and how you believe it should work from the perspective of Headquarters.

The Committee has seen problems with how specific programs—for example mental health services—are carried out locally, both in terms of network directors receiving guidance and Headquarters' consultants having even basic information as to the status of their respective programs. Such lack of control and oversight has been noticed in the areas of quality management, long-term care, mental health services, the maintenance of capacity, and on and on.

What do you believe is the appropriate role of HQ consultants in overseeing operations of their respective programs and do you believe this is occurring now?

Answer. I believe HQ consultants' primary roles are for program and policy development and for providing national level oversight of VHA's performance in their program areas. I expect HQ consultants to be advocates for their programs and to be part of the national leadership team that guides VHA activities. I believe HQ consultants are generally performing these functions, but will assure that expectations are clear, and over time I will review the consultants' performance in these areas.

*Question 1b.* In your view is it possible for the Under Secretary and those in Headquarters to actually manage the overall VA system?

Answer. I believe the best results are achieved when both field and Headquarters managers work together to establish goals and strategies for achieving the highest possible quality of health care services for our patients. VHA's achievements over the past few years could not have been accomplished with a top-down management structure and philosophy. VHA's Performance Measurement System provides both managerial direction and results tracking for field personnel; however this system must be carefully aligned with VA strategic goals for optimal results.

*Question 1c.* If confirmed, what changes would you propose so as to attempt to ensure that all aspects of VA health care management are covered?

Answer. I currently have no plans to change the management structure. I will work to assure that VHA's senior managers effectively carry out their responsibilities. This will be achieved, in part, by the introduction of a comprehensive strategic planning process, careful alignment of the VHA Performance Measurement System with strategic goals, and the use of crosscutting committees to maximize performance and reduce variance across all VISNs. If I find that changes are needed to improve VHA performance, I will not hesitate to propose those changes to the Secretary.

*Question 1d.* Please describe the operations of VISN 8 and how you interact with Headquarters, especially which offices you work with on a daily basis; which offices you turn to for guidance; and how you interact with other networks.

Answer. VISN 8 has frequent contact with all offices in VA headquarters (HQ). The most frequent contact is through the Office of the Assistant Deputy Under Secretary for Health, which maintains formal liaison in support of VISN offices.

VISN 8 frequently has contact and interaction with other Networks where organizational boundaries overlap state and congressional lines; where there is interaction to identify and advise on best practices; and for the purposes of external reviews, education, National Leadership Board, and patient transfers, among others. All VISN Chief Medical Officers work as a team and have a very collegial relationship with Clinical Programs in VA HQ. Consultations occur frequently and notification of program changes is done consistently. From a planning perspective, VISN 8 staff

have regular exchanges with the VHA Offices of Policy and Planning, Capital Assets, Financial, IT, and HR offices, as well as with their network counterparts.

*Question 1e.* If you are confirmed, what changes, if any, would you recommend to the Secretary regarding the current VISN structure?

Answer. I currently do not have plans to change the VISN structure. However, I would consider changes if significant improvement in health care delivery or cost effectiveness would result.

*Question 1f.* The General Account Office estimates that as much as one of every four medical care dollars is spent on building operation and maintenance.

What does your experience in VISN 8 tell you about VA's infrastructure maintenance costs?

Answer. Many of VISN 8's VA owned buildings are now exceeding 30 years in age, resulting in the need for significant infrastructure repair and improvements that surpass available funding. Through the recently completed VISN 8 Facility Condition Assessment, the most critical infrastructure problems have been identified and are being addressed first with available funding. The less critical are being done over time as resources become available.

VISN 8 is presently undertaking a $20 million Energy Savings Performance Contract that will, when completed, save about $2 million annually and reduce associated maintenance and repair costs. To further reduce indirect operational and maintenance costs, we have done some streamlining of facility and environmental management services between and within our medical centers.

*Question 1g.* What do you know about the experience in other networks?

Answer. While I cannot speak from first-hand knowledge of other networks, it is my impression that similar situations exist nation-wide.

I am advised that building maintenance and operating costs are generally lower than one in four dollars (25 percent). They are more in the range of one in six to one in eight dollars (12–16 percent). In follow-up meetings with GAO, it was determined that GAO had included all costs of capital operation, which, in their definition, was everything that was not direct patient care. Thus, hospital administrators, IT, medical library, and numerous other functions were applied to the building maintenance and operating costs.

*Question 1h.* How do VA's costs compare to the infrastructure costs in the non-VA sector?

Answer. I am advised that this issue has been reviewed in Phase I of CARES and by VA's Office of Budget. It has been found that VA's annual appropriations to cover infrastructure costs are between 30 and 50 percent less than the funds obtained for the same purpose in the non-VA sector.

*Question 2.* If confirmed, your term would run until 2006. Please describe your vision for the VA health care system by that year—specifically describe the mix of services that you believe enrolled veterans will receive, the makeup of staff providing these services, and a description of the VA facilities involved.

Answer. I believe that the VHA system will continue to change over time to adjust to changing patient demographics and health care needs. The veterans seeking VA care will be older, have more problems, and, in many cases, need expensive and/or specialized care, such as veterans with spinal cord injury. Our acute care facilities will continue to serve as the cornerstone of the VA healthcare system, but I believe we will see more care shifted from an institutional setting to an outpatient or home setting. VA will continue to need to focus on quality, access, and timeliness of care, as well as on patient safety and satisfaction. And certainly, VHA must concentrate medical research and education on issues specific to veterans and to military service.

*Question 3.* The FY 2003 budget request contains a proposal to enact a $1,500 deductible for Priority 7 veterans. VISN 8—specifically Florida—has more Priority 7 veterans than any other state. Given VA's assumption that the proposal will suppress demand and that veterans will, in fact, leave the VA health care system, what is your view of the deductible?

Answer. I am aware that the proposal was submitted as a part of the FY 2003 budget as an option for dealing with burgeoning demand for services within a fixed budget. VISN 8 is experiencing these pressures, as are many other VISNs. I believe that the Secretary expressed the dilemma that we face in your February 14 budget hearing. We do not want to exclude any group of veterans from the VA system; however, we must also assure that we maintain high quality services for all of the veterans that we serve. I am obliged to support the President's budget, but realize these competing goals could be served in a variety of ways. Clearly, I support the underlying principles of the proposal—to assure that we maintain the quality and accessibility to care for all of the veterans that we serve.

*Question 4a.* I am deeply concerned about VA's present approach to caring for veterans suffering from PTSD and other mental health disorders.

Please describe the priority that you believe VA should place on providing care to veterans with PTSD, and how you would ensure that priority is manifested in budget requests and programmatic planning?

Answer. The VA system of specialized PTSD clinical services is a vital resource not only for treating veterans who are currently our patients, but also for preparing for the consequences of future military deployments, for managing disasters at the local and national levels, and for training new generations of clinicians. I will work with the Mental Health Strategic Health Care Group, Readjustment Counseling Service, and the Under Secretary's Special Committee on PTSD to ensure that PTSD maintains its priority within budgetary and programmatic planning processes.

*Question 4b.* From your experience in VISN 8, what is your assessment of the unmet treatment needs among veterans with PTSD? What information to you have on this issue in other networks?

Answer. In 1999, Pub. L. 106–117, The Veterans Millennium Health Care and Benefits Act, required that $15 million be provided to enhance specialized treatment capacity for both substance use disorders and PTSD. Similar to other networks, VISN 8 conducted a needs assessment to identify gaps in its current services to PTSD veterans and received funding to enhance its PTSD services. I am aware that many other VISNs received funding from this initiative; however, I have not thoroughly reviewed other networks' PTSD programs and needs.

*Question 4c.* Based on your experience in VISN 8, please give your assessment of the Readjustment Counseling Service and the relationship to VA medical centers. Also please describe the relationship today—in VISN 8, and to the extent you can, nationally—between the mental health departments at VA Medical Centers and the Vet Centers.

Answer. The Readjustment Counseling Service (RCS) provides a model for providing treatment and establishing effective therapeutic relationships with veterans who often have great difficulty in trusting traditional institutions. In VISN 8, the Vet Centers and the Medical Centers have developed excellent cooperative relationships. RCS is part of our VISN 8 Mental Health Workgroup, and is involved in these decisions. Patients flow from one setting to the other, with staff from each feeling part of the same organization. This is an ideal relationship as it fosters a continuum of care, placing the focus of attention on the veteran. It needs to be disseminated throughout our organization.

*Question 5a.* As you know, in 1997, VA implemented the Veterans Equitable Resource Allocation (VERA) methodology to manage how funds are provided throughout the system.

In April 1997, just prior to VA's implementation of VERA, you testified before the House Veterans' Affairs Committee's Subcommittee on Health that you felt this model was "particularly well-suited to meet today's veterans healthcare needs because the plan will distribute federal dollars in a capitation-like manner." In 1999, VISN 8 required supplemental funding from the reserve to cover shortfalls and unmet needs. For FY 2002, nearly $300 million has been redirected to networks to cover similar shortfalls. Given the tremendous fiscal pressure faced by certain networks, are you still satisfied that this system is a fair way to allocate funds?

Answer. The supplemental funding received by VISN 8 in 1999 was directed primarily for repairs necessitated by catastrophic hurricane damage, something that cannot be incorporated into an allocation model. I believe that VERA still is a good system; some refinements are still needed, but, in general, it does accomplish what it was designed to do.

VERA has undergone extensive scrutiny to assess whether the model is meeting its goal of equitable and effective resource distribution. A Price WaterhouseCoopers LLP study (1998) and two General Accounting Office (GAO) reviews (1997 and 1998) viewed the progression of VERA in positive terms and as meeting the intent of Congress. Nonetheless, VERA continues to be a work in progress. Several VERA workgroups, comprising VHA field-based and Headquarters staff, provide ongoing evaluation of the VERA methodology and input on policy issues to improve VERA.

*Question 5b.* What is your view of using special purpose funding to emphasize key priorities, and specifically what is your view of the FY 2000 VHA increase for substance abuse and PTSD programs?

Answer. The use of specific (special) purpose funding for certain initiatives isolates those dollars for just the intended purposes. Monitoring of those dollars has been an issue that we are studying. Finding out if sufficient resources were provided, or determining the cost of a certain diseases, may be easier to ascertain if dollars are not co-mingled with other dollars, although some have argued fencing

dollars in this manner may discourage the most effective utilization of the funds. Another tracking mechanism that is being carefully evaluated in this regard is the DSS system, which can yield very detailed cost and expenditure information.

Special allocations such as the VHA FY 2000 increases for PTSD and Substance Abuse are appropriate mechanisms that permit more directed assignment of resources to meet significant veteran needs.

*Question 5c.* In your view, does VERA sufficiently allow VA managers to sustain programs for high cost patients and patients in need of specialized services?

Answer. Yes. However, VHA is actively evaluating how to improve VERA's case-mix adjustment and other cost factors. VERA is not a static model; rather, it is reviewed and refined on an ongoing basis through internal workgroups and external studies. VHA is currently evaluating a revised VERA case-mix adjustment, and a mechanism to offset the cost of networks' highest complex care patients.

*Question 5d.* In October 1998, VA contracted with Price Waterhouse to evaluate VERA. The contractor recommended a series of modifications—most notably that VA implement a transfer pricing system. This was to be tested and implemented last year. What is your view on this recommendation?

Answer. Other than the use of pro-rated patients (PRPs), transfer pricing was never implemented. It was found that the costs of implementing a transfer pricing system far out-weighed the potential benefits. In addition, there was no clinical evidence that transfer pricing improved the coordination of clinical care for patients that receive care in more than one network. At this time, I plan to maintain the VERA PRP methodology for funding care across networks, and will encourage networks to conduct whatever intra-network transfer pricing funding distributions they deem necessary to meet local patient care needs.

*Question 5e.* A 2001 RAND Study suggested that changes be made to the VERA methodology on case-mix refinement and that there be a geographic price adjustment for contract labor and non-labor costs. What is your view of this recommendation?

Answer. VISN and facility directors have frequently reported difficulty in managing the cost of contract services, particularly in rural areas where the choice of providers is relatively limited. I concur with VHA's decision in the FY 2002 VERA methodology to better account for local cost of living factors associated with procuring contract labor and non-labor contracted goods such as energy-related products, utilities, and provisions. The existing VERA labor adjustment methodology is now applied to the cost of contracted labor and non-labor contracted goods. This refinement to VERA will account for expenses caused by geographic cost factors beyond a network's immediate control.

In its Phase I VERA study, RAND identified a number of issues that it will address in Phase II by conducting a quantitative analysis. These issues include improved case-mix adjustment, geographic differences in prices paid for non-labor inputs and contract labor costs, the impact of teaching and research hospital affiliations, and the impact of the facilities' physical plants. VHA now looks forward to receiving RAND's additional input and recommendations, particularly on case mix and geographic price adjustments.

*Question 6a.* As you may know, I am deeply concerned about issues relating to long-term care services and delivery in VA.

Based on estimates, the number of veterans age 85 and older will dramatically increase—from 154,000 in 1990 to 1.3 million in 2010. If confirmed, what changes would you seek to implement to allow VHA to respond to the impact of this looming change?

Answer. If confirmed, I will continue to move VA toward a patient-centered continuum of care that can meet the special care needs of an aging veteran population. In responding to the needs of the over age 85 veterans, we will move forward to improve access to preventive, acute and long-term care (LTC) services, with the goal of maintaining functional abilities of these veterans so they can remain in their homes and communities for as long as possible. VA has made considerable progress toward organizing a geriatrics and LTC system that can respond to shifts in demand and to changes in local healthcare market characteristics, and provide seamless care. We have launched major national initiatives to improve end-of-life care and pain management for veteran patients. I fully support expansion of home and community based care, innovative public/private partnerships for LTC, and performance improvement goals for assuring the continued quality of geriatrics and extended care services. Preliminary results with this approach in VISN 8 have shown a higher level of patient satisfaction and lower hospitalization rates, with a dramatic reduction in the overall cost of care. In addition, I would accelerate the training of our professional staff in the nuances of care for the elderly.

*Question 6b.* Please share what guidance you have received as a VISN director on the law which requires non-institutional long-term care services be made a part of the standard benefit package. What was your response to that guidance? What contact have you had with other network directors on the benefit expansion?

Answer. As a VISN Director, I received periodic status reports on the implementation of the long-term care provisions of the Millennium Act and directives issued from Under Secretary for Health related to the implementation. The Directive on Non-Institutional Extended Care within VHA was issued in October 2001. Prior to that time, the VISN 8 Extended Care Workgroup utilized the law and VHA regulations and existing directives to develop a LTC plan for this network. The policies they developed were approved by VISN leadership and implemented VISN-wide. The Community Care Coordination Service was a clinical and financial commitment made by VISN 8 to respond to both the rapid growth and need to provide more non-institutional care. The results of expanding non-institutional care have been the following:

- improved functional status,
- reduced premature institutionalization,
- decreased nursing home placements (by 64%),
- comparable group increased placements (by 106%), and
- veteran satisfaction with alternative approach exceeding 90%.

*Question 6c.* How will you encourage cooperation with others (state homes, affiliates, and community providers) to offer veterans the very best long-term care in the most cost effective manner?

Answer. For FY 2002, VHA has a Budget Performance Measure calling for an ambitious 34% increase in the number of veterans receiving home and community-based care compared to FY 2001. We plan continued increases each year to a goal of 34,500 average daily census in FY 2006. To achieve these goals, we will expand both the services VA provides directly and those we purchase from affiliates and community partners. We will meet most of the new need for long-term care through non-institutional care as home health care, adult day health care, respite, and homemaker/home health aide services. Since some long-term care must be provided in an institution, we will maintain our current VA nursing homes, utilize the ongoing expansion of state homes, and meet remaining need by purchasing care through the Contract Nursing Home program. In addition, we will enhance the efficiency of long-term care through creative use of existing resources, including the provision of Adult Day Health Care at state home facilities.

*Question 6d.* Some outside experts have argued that VA long-term care is often under-funded relative to non-VA long-term care. What is your view of this?

Answer. There have been no major shifts in the funding of Long-Term Care services either within VA or in large state or other federal health care systems. The President's Budget for FY 2003 shows VA spending 12.9 percent of its total health care funds on LTC services. This is a decline of less than one percent over the last five years. VA's experience in LTC funding mirrors most State Medicaid Programs. What appears to be lacking is full implementation of an aggressive home- and community-based care strategy. The FY 2003 budget suggests such an approach, and its adoption would move VA towards an appropriate position of leadership in LTC service delivery. As VA grows, its home care programs, nursing home care expenditures will need to stabilize. VA should examine the feasibility of targeted trade-offs between and among nursing home and home care and outpatient services.

*Question 6e.* What are your views about VA-community joint ventures, such as Alzheimer's disease facilities?

Answer. I strongly support the concept of VA-community joint ventures as a way of leveraging resources and enhancing the quality, availability, and cost-effectiveness of services. VA is developing a variety of joint projects through its enhanced-use lease (EUL) authority, and we have actively encouraged the use of EUL for services such as assisted living, which VA has limited or no authority to provide. Additionally, we expect to learn a great deal more about the best ways to combine VA and community services as a result of the pilot programs relating to long-term care and assisted living that are currently underway as part of the Veterans Millennium Health Care and Benefits Act.

Joint ventures will help expand our capacity for serving veterans with Alzheimer's disease, as well as other disorders. For example, VA is currently participating in "Chronic Care Networks for Alzheimer's Disease," a national demonstration project co-sponsored by the national Alzheimer's Association and the National Chronic Care Consortium (NCCC), in which VA's Network 2 (Upstate New York) and seven other NCCC members are working in partnership with Alzheimer's Association local chapters to design, implement, and evaluate a model of coordinated acute, primary, and long-term care for persons with dementia. Results will be used to disseminate new

collaborative models of chronic care to all VA networks, as well as for geriatric care throughout the country.

VA facilities planning enhanced-use lease projects or other joint ventures should also consider the special needs of veterans in the early or later stages of dementia. For example, a "Veterans Village" type of retirement and continuing care community would ideally include varying levels of services for veterans with dementia as well as those with other disorders. Given that there are many unresolved questions about "best" care for persons with dementia, careful evaluation of new joint venture programs for dementia care will be very important.

*Question 7a.* In recent years, VA's quality management program has seen some significant improvements. What priority will you give to Quality Management in the Veterans Health Administration?

Answer. Supporting quality and quality management activities will be one of my highest priorities. Quality management is an essential element in a national health care system committed to excellence. It must be embedded in our core processes through a comprehensive performance management system that aligns VHA's vision and mission with quantifiable strategic goals, defines measures to track progress in meeting those goals, holds management accountable through performance agreements for results achieved, and advances quality within the context of patient-centered care across the continuum of care. I will continue to look to system-wide approaches that integrate quality management strategies across traditional organizational lines.

*Question 7b.* If confirmed, will you increase support for the VHA Quality Management Program, not only in established VA medical centers, but also in the many newly established Community Based Outpatient Clinics, whether operated by VA or by contractors?

Answer. All Veterans should have access to a single standard of care regardless of the site of care. VHA promotes quality management through a variety of mechanisms across the system, including development of clinical practice guidelines, evaluation of performance measures directly related to VHA's strategic goals, monitoring the external accreditation of facilities, and monitoring and improving the credentialing and privileging process, among other initiatives. I fully support oversight of quality, access, and safety system-wide in all settings and encourage quality measurement programs that provide valid, reliable data for a comparison of performance at the Network, facility and CBOC levels. This approach provides the necessary strategic information on which actions can be taken immediately to improve the quality of care.

*Question 7c.* In your view should VHA continue its support of, and involvement in, the National Practitioner Data Bank and VETPRO programs? Should the level of support and involvement be increased?

Answer. I believe that VA should continue to participate in the National Practitioner Data Bank (NPDB). VA queries the NPDB and obtains available information concerning physicians, dentists, and other health care practitioners who provide or seek to provide health care services at VA facilities as members of the medical staff. VA reports to the NPDB on physicians who fail to meet Nationally recognized standards of care.

I believe that VA should continue to support VetPro to ensure consistency of the credentialing process and to support high quality and safe patient care. VetPro provides VA with the ability to maintain a common, valid, and reliable electronic data bank of health care provider credentials. VetPro credentialing results in greater safety and security for patients, greater efficiency for clinicians and health systems, and facilitates cross-utilization of medical personnel between facilities and Networks.

*Question 8.* The relationship between VA medical centers and medical schools has endured for more than 50 years. I am concerned about the viability of the relationship, however, especially in light of a recent CARES decision. Please share your philosophy regarding the overall value of academic affiliations, including the role affiliates play in staffing VA facilities and how you believe they should be involved in the CARES process.

Answer. I value the role these affiliations play in assuring excellent care for our nation's veterans. As VA goes forward with CARES, I believe we need to actively involve our affiliates throughout the process to find innovative solutions to the changing health care environment.

*Question 9.* How will you encourage the non-veteran health care system to better understand the VA health care system?

Answer. The Veterans Health Administration has developed a comprehensive communications plan that targets each of VA's stakeholder groups and audiences—both internal and external. The plan is designed to sharpen and focus VHA's mes-

sages, improve the flow of information, and foster awareness and understanding of our programs and activities. Its primary objective is to draw deserved attention to the quality of our health care; our achievements in medical research; the value of VHA's partnerships with medical schools and how those affiliations educate our nation's health care professionals and affect the quality of everyone's health care; and the critical role VHA plays in homeland security.

*Question 10a.* There has been a push, mostly from within VA, to encourage more cooperation and sharing agreements between the VA and the Department of Defense (DoD). What areas do you see as having the most potential for new sharing arrangements?

Answer. The areas that have the most potential for new sharing include:

- joint procurement of medical/surgical supplies, high tech medical equipment, and commodities;
- collaboration in information management/information technology (IM/IT), particularly in developing standardized, interchangeable electronic medical records to support health care delivery and common standards for IT architecture, data, communications, security and systems;
- implementation of a joint protocol for a common physical examination for both discharges and disability compensation evaluation;
- coordination of efforts to enhance homeland defense and respond to the medical needs of victims of terrorist activities;
- medical and educational support for military reservists and members of the National Guard;
- collaboration to make the TRICARE co-payment structure an incentive for beneficiaries to obtain health care from VA; and
- a coordinated and collaborative process for planning health care facility construction.

*Question 10b.* What would you do to bring DoD to the table to bring about more sharing successes.

Answer. I would continue the efforts of the reinvigorated VA/DoD Executive Council. I would push it to be more of a deliberative, decision-making body with specific timelines for actionable issues. My initial focus will be on the nature of the relationship between VA and DoD and assuring that there are appropriate incentives for TRICARE beneficiaries to seek care at VA.

I support the efforts of the President's Task Force to Improve Health Care Delivery of Our Nation's Veterans, as well as the Departmental level Executive Council that has recently formed. I believe that we need better data collection of on going activities. We need to look for new models of collaboration and sharing. With my background in the Reserves, I feel I have sufficient knowledge of both systems to move the relationship forward in a positive manner.

*Question 11.* A Medicare+Choice subvention pilot raised costs for DoD. Given your health care financing experience and knowledge of VA, do you believe that VA could gain revenue by implementing a similar subvention pilot?

Answer. As stated in a recent GAO report on the DoD subvention demonstration, one of the biggest challenges for DoD was to maintain costs while managing the care given to the Senior Prime beneficiaries. Historically, DoD's health care delivery system was not as well positioned to provide care to the elderly population as the VA health care delivery system. Additionally, when the retiree's care was referred to providers in the civilian network, the local military treatment facilities (MTF) had no direct financial incentive to manage the care, since DoD, not the MTF, provided the funds. Also, incentives lacked for the managed care support contractors to limit utilization in the demonstration. These contractors authorized network services, but bore no risk for the costs of enrollees' care.

If VA were to undertake a subvention pilot similar to the demonstration DoD undertook, we would need to change some of the operating principles to address problem areas that DoD encountered. I could not predict the revenue gains or losses for VA, but I believe that VA has a better handle on health care utilization management and therefore managing our costs.

*Question 12.* On the issue of medical record privacy, please share your thoughts about the widespread access to medical records within VA. How do you understand the HIPAA regulations will affect VA's current process relating to access to medical records?

Answer. VHA's privacy and information security programs emphasize training of all users, and all new employees receive Privacy Act training. VHA policy in accordance with the Privacy Act, requires local safeguards be established concerning patient record security and confidentiality. These safeguards include, but are not limited to, the following:

- limiting access to patient record file areas to authorized personnel;

• controlling records which are removed from the facility for any reason;
• locking patient record file areas and other areas where patient records are temporarily stored (patient record review areas, quality assurance areas, release of information areas, etc.) when responsible personnel are not present to ensure the security of the area;
• physically locating patient records in the treatment areas so that they are not accessible to unauthorized individuals, such as visitors;
• ensuring that the use of computer access codes meet all laws and regulations;
• appropriately labeling "sensitive" records in the computer;
• restricting release of information activities to personnel who are assigned that responsibility;
• taking precautions to ensure that patient records on computer screens cannot be seen by those who do not have a legitimate need-to-know;
• protecting records from potential physical damage by fire, water, animals or insects; and
• having an adequate disaster recovery plan for both hard copy and computer records.

*Question 13a.* The Administration's FY 2003 budget request relies heavily on copayments from veterans and collections from third party insurance. VA is estimating $1.5 billion in collections for FY 2003, doubling the amount from FY 2001. What changes to the MCCF program do you envision to improve third party collections?

Answer. In his testimony before this Committee, Secretary Principi outlined the broad parameters of the improvements contemplated for the Department's billing and collection efforts for third party payers. The bases of those improvements are derived from the Revenue Improvement Plan that was developed in collaboration with an external contractor. Twenty-four actions were identified that would yield significant enhancements to our ability to collect revenue. Management policies, management practices and procedures, information technology, human resources, and refocusing corporate culture are all being subjected to review and improvement. Although some of these require time in order to reap full benefit, VHA has already noticed significant increases in revenue. During October 2001 and January 2002, collections exceeded $80 million.

In summary, VHA envisions three broad-sweeping activities that will have a profound impact upon the MCCF program.

1) Electronic Data Interchange (EDI) effort. EDI will enable VA nationally to transmit data through a clearinghouse to third-party payers. This should result in more timely payments by ensuring that bills are transmitted electronically to the payer. I am pleased to state that we are actively working toward this conversion and have already implemented many changes to our processes and systems to increase electronic processing of claims.

2) Centralization and/or consolidation of like functions in the revenue process. Centralizing similar functions may produce greater efficiencies and economies of scale. Several organizations within VHA already have either centralized their revenue operations or consolidated their billing and collection efforts.

3) Outsourcing and contracting out revenue-related functions.

*Question 13b.* VA can not charge a copayment that is more than the cost of a prescription. To justify the recently announced $7 prescription copayment amount, VA included a myriad of administrative costs. Do you feel that this charge is appropriate for over-the-counter medications such as aspirins, vitamins, and cough syrup?

Answer. The medication co-payment is assessed to certain veterans for medication received for a non-service-connected condition, and over-the-counter medications are subject to the $7 co-payment. Although this may appear to be a high price for these items, Pharmacy staff do perform the administrative functions involved in dispensing these medications. However, Public Law 106–117, which gave us discretionary authority to set pharmacy co-payments, also provided that a higher medication co-payment could be charged for medications described as "quality of life" drugs. I will encourage continuing discussions within VHA on the possibility of implementing a tiered medication co-payment system, whereby a lower tier is established for over-the-counter items and low cost medication.

*Question 13c.* If confirmed, would you recommend that the $7 copayment amount be increased in the future?

Answer. I am advised that VHA would propose increases periodically based on the Prescription Drug Component of the Medical Consumer Price Index.

*Question 13d.* What is your view of contracting out portions of the MCCF collection effort? What was your experience as a network director in contracting out revenue generating functions?

Answer. The following revenue functions were contracted out during my tenure in VISN 8:

CODING—Due to the difficulty in recruiting and retaining qualified coding staff, several facilities contracted portions of the coding function to outside vendors. This allowed VISN 8 to successfully increase collections over the last few years.

BILLING AND ACCOUNTS RECEIVABLE—We have had experiences in VISN 8 facilities in contracting out portions of billing and accounts receivable activities. At our San Juan facility, an outside vendor works in conjunction with hospital staff to prepare bills and collect accounts. Due to the combined effort of the contractor and VA oversight, the San Juan facility experienced increased collections of $1.4 million (FY 2001 vs. FY 2000).

PRE-REGISTRATION—Several facilities have used contract staff to pre-register patients prior to appointments in order to update demographic and insurance information. The pre-registration effort has improved insurance identification through use of periodic updates via telephone prior to the appointment date.

From these experiences, it is my belief that contracting out portions of the MCCF collections functions can, in many circumstances, play a beneficial role in our overall efforts to improve revenue collections. I know that other networks have also had positive experiences in this area. I believe that VA, as a whole, should pursue this avenue where it proves effective and returns value for cost.

*Question 13e.* Please provide information about the collections activities in VISN 8, including any successes you achieved and the type of information and guidance you received from Headquarters on your collections effort.

Answer. VISN 8 led the nation in cumulative collections in FY2001 with a total of $65.3 million dollars collected, increased collections from FY 2000 by $22 million, and achieved 140 percent of MCCF Revenue Goal for FY 2001. In FY 2002, VISN 8 has collected $26.4 million through January, which is the highest cumulative total of any VISN and 9 percent of the entire VHA collections total.

VISN 8 has established a VISN wide Network Revenue Team, which meets on a regular basis to discuss issues and share best practices. In addition, each medical center has organized a local revenue team to address issues related to insurance, billing, coding and documentation.

In concert with senior managers, VISN 8 implemented several best practices for identifying insurance including: pre-registration, VISTA insurance reminders, and veteran insurance inquiry at each visit, and insurance tracking statistics. VISN 8 also implemented a pharmacy co-payment call center, which handles co-payment inquiries from veterans located throughout the state of Florida. The call center has improved customer satisfaction, streamlined process and freed up MCCF staff in medical centers to concentrate on billing and collection activities. The network also developed a participating provider agreement with a major insurer, which allowed it to improve payment rates and timeliness of payments.

*Question 14.* Do you believe that the VistA system is still able to meet the clinical and administrative needs of VHA?

Answer. VistA was originally built to support individual medical center/inpatient care models. In VistA, our clinicians have available a powerful set of tools that improve their ability to provide excellent patient care. At the same time, however, it is an aging system. The software has undergone numerous modifications as VA evolved to an outpatient-centric system of care. It is also built on older technology. Thus, it is a system that is fragile to maintain and cumbersome to enhance.

Through the HealtheVet strategy, VA will ensure that VistA remains a high performance system, and that we meet new requirements of our future health care system. At this time, I believe HealtheVet is a sound strategy to successfully accomplish these goals.

*Question 15.* The Committee understands that several clinics, including some in Florida, have stopped seeing new patients. Please provide detail on any such changes in VISN 8 and any information you have about other networks.

Answer. In VISN 8, nine of 44 clinics currently exceed maximum capacity (based on average panel size for primary care providers) and cannot serve additional veterans at this time. These clinics include Viera, Brooksville, Zephyrhills, Lakeland, Kissimmee, and Sanford under Tampa VAMC; and Delray Beach, Stuart, and Boca Raton under West Palm Beach VAMC. New veteran applicants seeking care at these sites are being redirected to the parent medical center for care.

Other clinics in VISN 8 are assigning new patients as clinic slots become available. Waits by new enrollees can be as long as 6 months to a year when their medical need is not urgent. However, patients requiring urgent care are seen immediately.

*Question 16.* How many of the VISN 8 CBOCs offer mental health services? Please also describe how you manage these clinics, for example, the process you use to evaluate and renew contracts for CBOC providers?

Answer. VISN 8 has 10 large multi-specialty clinics and 34 primary care CBOCs. All 10 multi-specialty clinics and 9 of the 34 CBOCs currently provide Mental Health services on site. VISN 8 Plans call for mental health resources either through staff on site or through a tele-psychiatry pilot at 17 additional CBOCs in the near future. For the remaining CBOCs, tele-psychiatry will likely be utilized if the tele-psychiatry pilot proves successful. The tele-psychiatry pilot will primarily be conducted at contract CBOCs, none of which currently have mental health services on site.

Of over 630 clinics nation-wide, approximately 34 percent are contracted. In VISN 8, 13 of 44 clinics (30 percent) are contracted. Quality of care indicators, patient satisfaction surveys, workload productivity, and cost-effectiveness are evaluated on a regular basis at all VISN 8 clinics. Using a set of quality measures and other parameters, a special study by the VISN 8 Measurement Support Team is also underway to compare quality of care and cost-effectiveness at contracted versus VA-staffed CBOCs.

In addition, a VISN 8 CBOC Taskforce is developing a uniform process across the VISN for monitoring and managing CBOC contracts. The Taskforce has reviewed all of the current CBOC contracts and has developed a template of items that should be included in all contracts VISN-wide. Taskforce members will ensure that all contracts, upon renewal, will be revised by fully addressing each of these factors.

*Question 17a.* Non-physicians providers are critical to the VA health care system. Please describe what you see as the future role within VA for non-physician providers, such as physician assistants and advanced nurse practitioners.

Answer. Properly credentialed and licensed non-physician providers will continue to serve an important role in VHA in a variety of practice settings. Their roles may include:

- performing history and physical examinations;
- ordering and interpreting diagnostic studies;
- diagnosing and treating illness;
- educating patients and prescribing medications, and
- providing health promotion and disease prevention services.

*Question 17b.* For years, VA physicians assistants have not been required to retain State licenses to practice and prescribe medications within the VA health care system. The directive outlining the requirement that they have certification in lieu of state licensure expired last year, and PAs currently are operating under an interim guidance directive. VA is reviewing whether or not state licensure should be required. What is your view of how this issue should be resolved?

Answer. The current interim directive stipulates that an individual must hold a state license that allows prescriptive privileges in order to write prescriptions. In the case of physician assistants, a state license, registration, or certification may be accepted, since some states certify or register rather than license physician assistants. I understand that a revision to VA regulations is under development that would permit non-physician providers to write prescriptions only if the state where the provider is licensed permits the provider to prescribe. I believe that this is an appropriate way to ensure the quality of care to our patients. However, we must evaluate any untoward effects that the implementation of this new regulation would have on our workforce and the patients they serve.

*Question 18.* Please describe any recruitment and retention problems involving health care personnel you have seen in VISN 8 health care facilities. What would you suggest to respond to these difficulties?

Answer. VISN 8, like many networks, has experienced recent difficulties in recruiting nurses, particularly in critical care areas and for evening and night shifts on inpatient units. High seasonal demand for care leading to a higher average daily inpatient census has exacerbated this problem during the winter months. We have also experienced difficulties in recruiting scarce specialty physicians. There is no simple answer to these recruitment difficulties. Rather the answer lies in a series of actions that will enhance VA's perception as an employer of choice, expand employee benefits, increase flexibility in personnel actions related to hiring and part time employment, and improving both nurse and physician pay comparability to their non-VA counterparts.

*Question 19.* In the past, VA has had increasing difficulty recruiting and retaining an adequate number of high quality nurses. Please describe what you see as the current role of nurses in the VA health care system, and how that might change, if at all, over the next 20 years.

Answer. The Department of Veterans Affairs offers veterans one of the largest, most comprehensive health care systems in the country. Within this context, nurses are vital contributors in the delivery of healthcare to veterans. VA nurses are engaged in clinical practice, administration, research, and education. Their practice settings embrace all aspects of the continuum of care within the Veterans Health Administration ranging from in-patient settings to primary and home-based care to specialty clinics.

Over the next 20 years, VA nursing practice will certainly reflect such change in response to patient care demands. Technological advances in health care treatment and equipment, evolving health care trends, modifications in delivery settings, and consumer expectations will require nurses to constantly adapt to change. The expanded roles of nurse practitioners and clinical nurse specialists will continue to increase with nurses assuming greater responsibilities for the provision of primary care and the management of chronic conditions. Moreover, VA nurse involvement in home-based and community care will increase as families become more involved as non-traditional caregivers.

*Question 20a.* VA research not only makes a major contribution to our national effort to combat disease, but also serves to maintain a high quality of care for veterans through its impact on physician recruitment and retention.

In your view, what should be the goals of VA's research program?

Answer. In my view, the purpose of VA research program is to discover knowledge and create innovations that advance the health and care of veterans and the nation. I am advised that specific VA research goals include:

- Sustain a superior environment of inquiry conducive to the highest quality research, education, and patient care.
- Effectively integrate basic, clinical, and applied research to best meet veterans' health care needs.
- Effectively transfer research results to advance veterans' healthcare.
- Capitalize on VHA's value as a national research asset.
- Lead and manage an effective and efficient research enterprise.
- Increase awareness and understanding of the value of VHA's research contributions.

*Question 20b.* What are your views on the importance of VA research compared to funding for services?

Answer. They are integrally linked; both are important. Investment in research ensures that we continue to build the knowledge base essential for ensuring high quality, efficient health care services, particularly in areas important to our nation's veterans. Research helps VA reduce health care costs, improve the quality of our care, and point the way toward improved access for all veterans to the service we provide.

*Question 20c.* What can be done to combat the chronic under funding of the VA research program?

Answer. I believe that VA needs to continue and, if possible, enhance the value of VA research and continue to leverage VA appropriated research funds by partnering with other sponsors of research including the National Institutes of Health, the Department of Defense, and private industry.

*Question 20d.* How do you think VA should allocate its limited research funds among the general areas of basic, applied clinical, and health services research?

Answer. The full spectrum of research is important, and the divisions articulated imply a false separation. For example, much of health services research also is applied clinical research. Similarly, much applied clinical research cannot proceed unless the underlying basic research has been conducted. Funds should be allocated on the basis of relevance to the high priority healthcare needs of veterans, scientific opportunity, and rigorous merit review.

*Question 20e.* Do you support adding a provision to the law which would authorize strengthen Federal Tort Claims Act coverage for the employees of VA-affiliated nonprofit research and education corporations?

Answer. I have not had the opportunity to fully review this question, but believe that it is an important one. The nonprofit research corporations add significantly to VA's ability to fulfill its research and education missions, and I believe we should fully support these activities towards these goals. I will undertake a review and provide the results to the Committee.

*Question 20f.* Recognizing that designating time for clinician investigators to conduct research and providing them with adequate infrastructure are continuing problems in VA, would you support addressing this by administering investigator salaries and facilities operation costs centrally, in a manner similar to that used by NIH, to ensure that VA-funded investigators have adequate time and resources to conduct research?

Answer. The VA indirect costs associated with research are currently distributed using a research adjustment to the VERA model. At this time, I do not believe that further centralization of these funds is needed.

*Question 21.* What does your experience tell you with regard to women veterans' access to VA health care services, notably mental health services? What changes, if any, would you propose in this area if confirmed as Under Secretary?

Answer. Women veterans represent a rapidly growing portion of the veterans we serve. I am proud of the efforts of our organization to provide services tailored to their needs. I am particularly pleased with the efforts of the mental health professionals in VISN 8 who have assigned staff to specifically support such programs. This has required the cooperative efforts of Vet Centers, PCT teams, and specialized sexual trauma units. Efforts such as these need to be encouraged.

Experienced providers tell us that when mental health services for women are co-located with the physical health services, both providers and patients are more comfortable with the care. Several facilities around the nation have taken this approach, and where it is successful, it is considered a Best Practice model. A VA program for intensive treatment of sexual trauma has been developed at the Bay Pines VAMC in Florida, which sponsors short training programs for VA providers across the country. This could be a model for treating some of the other disorders primarily affecting women, and training VA clinicians to provide this care.

*Question 22a.* A major concern of mine and others on the Committee is the question of the exposure of military personnel to potentially harmful substances during their service—especially in times of war.

In your view, what is VA's role in attempting to ensure that men and women who serve in our nation's military are protected from toxic exposures which might ultimately harm them? What do you envision to be VA's role in monitoring to ensure that servicemembers are protected?

Answer. VA has a strong interest in following the health of veterans who have separated from military service, and whose health may have been affected by their military experience. As the lead federal agency on Gulf War related research, VA has been responsible for coordinating federally sponsored epidemiological and other relevant scientific studies. As a whole, the research program has focused upon specific questions related to the Gulf War. However, there is an appreciation that the issues involved extend beyond this cohort of veterans and include a broad range of health effects that may be associated with all military deployments. The lessons learned from this integrated Gulf War research program will provide insights into anticipating, diagnosing, and treating the health needs of future returning veterans and their families, including veterans from our current war on terrorism.

*Question 22b.* What efforts are being made in VISN 8 to ensure that Gulf War veterans, still suffering from undiagnosed illnesses, are receiving the specialized care they need at their local VA medical centers? What information do you have about other networks and what guidance on this subject have you received from Headquarters?

Answer. VISN 8 has used serial SF36V evaluations to assess the status of the mental and physical health of Gulf War veterans throughout the network, and to track changes in their status over time. The network also established an innovative interdisciplinary treatment program for Gulf War veterans at the James A. Haley VA Medical Center in Tampa. This program serves as a referral center for Gulf War veterans across the entire network.

VA has several programs that focus upon those veterans with undiagnosed war-related illnesses. Based upon our experience with veterans from previous conflicts, we now appreciate that combat casualties do not always result in obvious wounds, and that some veterans from all conflicts or peace-keeping missions will inevitably return with difficult to diagnose yet nevertheless debilitating health problems. We have seen that Gulf War veterans as a group report a variety of chronic and ill-defined symptoms including fatigue, neurocognitive and musculoskeletal problems, at rates that are significantly greater than for their non-deployed peers. This has required that we develop new ways of responding to the health needs of these veterans.

In response to the clinical needs of Gulf War veterans with difficult to diagnose yet sometimes debilitating symptoms, VA, in collaboration with DoD, are developing new Clinical Practice Guidelines for Post-Deployment Health and for two symptom-based illnesses, Chronic Fatigue Syndrome and Fibromyalgia. These new Guidelines, which the Institute of Medicine has highly recommended, will give VA primary care providers the tools they need to diagnose and treat veterans with such illnesses.

VA also has developed an independent study guide "A Guide to Gulf War Veterans' Health," to ensure that all Gulf War veterans coming to VA facilities will en-

counter health care providers who are knowledgeable and sensitive to their health care concerns. All our health care providers are encouraged to take advantage of this training.

*Question 22c.* Are ill Gulf War veterans in VISN 8 being followed by a designated physician who is kept informed of the latest information pertaining to Gulf War illnesses and can coordinate the veteran's medical care? What information do you have about other networks and what guidance on this subject have you received from Headquarters?

Answer. All VA Medical Centers, including those in VISN 8, operate VA Gulf War Health Examination Registry programs. These programs involve both a registry physician and registry coordinator. VA established this registry in response to the immediate health concerns of returning Gulf War veterans. Modeled after the VA Agent Orange Registry program for Vietnam veterans, the Gulf War Veterans' Health Examination Registry incorporates data on symptoms, diagnoses, and reported hazardous exposures of Gulf War veterans who come to VA for this systematic clinical examination. Registry physicians can make referrals to other health care specialists, as needed.

VA operates several programs to keep primary care providers and the registry staff informed about the latest information on Gulf War illnesses. These include self-study guides on Gulf War health issues; quarterly conference calls to update all registry staff on Gulf War health issues; regular mail-outs of new publications and other documents; and, a VA Gulf War web site that includes reports on a wide range of Gulf War health issues.

*Question 22d.* Is there still a Gulf War coordinator within each VAMC within VISN 8, and, if so, what is their current role? What information do you have about other networks and what guidance on this subject have you received from Headquarters?

Answer. Every Medical Center in VISN 8 has a designated Gulf War physician coordinator, whose duties include assuring that the comprehensive healthcare needs of Gulf War veterans are fully met. Generally, all VAMCs in all VISNs have Gulf War Registry Physicians and Coordinators. In a few cases, following reorganization of a VA facility, the registry coordinator is located at the primary or main hospital and coordinates activities for satellite facilities. The roles of the physicians and coordinators are to coordinate Registry Examination appointments, conduct the Registry Examination, make referrals to other specialists as needed, communicate results to the patient, and to report the results of the registry examination to VA Central Office.

*Question 23.* Recently, we received reports about financial mismanagement involving the Tampa-Hillsborough Action Plan—a community-based homeless program that received grant money through the Grant and Per Diem program. What steps do you think need to be taken in order to ensure better oversight of such program recipients, particularly in light of the fact that the program's authorization was just increased?

Answer. First, I would like to acknowledge the success of VA's Homeless Providers Grant and Per Diem (GPD) program. The GPD Program has quickly expanded from a small capital funds competitive grant program in 1994 to a nationally recognized community-based VA funded initiative operating in partnership with non-VA agencies providing more than 2,500 transitional housing beds throughout the country. Over 5,000 homeless veterans received services under the GPD during the last fiscal year.

By the end of FY 2001, VA had provided more than $63 million in grants to non-profit or state and local government agencies to assist in the creation of over 100 supportive housing programs or service centers around the country. In addition, VA had distributed more than $45 million to medical centers to provide per diem payments to assist these organizations in defraying the costs of programs operations. It is expected that within the next five years the number of programs and community-based transitional housing beds will double.

With the increasing emphasis on and need for the utilization of medical center staff for the development and oversight of community providers offering services for homeless veterans under the GPD program, comes the need for enhancement of and increased delineation of tasks for those VA staff in liaison roles.

The Secretary's office in consultation with the Director, VA Homeless Programs and Associate Chief Consultant, Health Care for Homeless Veterans Programs has developed a nation-wide Action plan to: 1) increase assurances that veterans in GPD funded community-based project sites are receiving quality services; and 2) enhance safeguards to prevent conflict of interest between VA employees and the GPD funded community provider organizations. The steps in this action plan are currently being implemented and should be fully incorporated into Grant/Per Diem Program

management process by the end of the year. I will support these efforts and I will also ensure that these action steps—designed to increase VA's abilities to provide oversight of GPD community programs—are carried out to the fullest extent.

*Question 24a.* It is my sense that VISN 8 has done a very good job in preparing for the potential medical consequences of a terrorist attack. Given your experiences there in encouraging medical readiness for deliberate and natural disasters, especially in building strong regional partnerships, how do you think you might foster a similar degree of preparedness throughout the VA healthcare system? What information do you have about other networks and what guidance on this subject have you received from Headquarters?

Answer. I will continue to urge preparedness by issuing specific guidance to VISNs and VAMCs. I will also continue to apply the expertise of VHA's Emergency Management Strategic Healthcare Group (EMSHG) and its field based Emergency Managers, as well as guidance from the EMSHG Technical Advisory Committee. It is critical that we support our system by providing them the tools, i.e. the most current information on emergency management, weapons of mass destruction (WMD) and related subjects and urge their involvement in education, training, and exercises with community partners. I will also urge participation in national videoconferences, training, and other initiatives that we can provide from VACO.

Some VISNs already have appointed task forces to address medical readiness. Some have highly trained teams and equipment. Examples of current initiatives include VISN 8's Hazmat team and decontamination system, Emergency Medical Response Teams (EMRTs) in VISNs 4 and 7, and Hazmat teams and decontamination facilities in Washington DC, Indianapolis, and Little Rock. Last year, 40 VAMCs hosted the Hospital Domestic Preparedness training presented by the US Army Soldier and Biological and Chemical Command (SBCCOM). VHA has just completed a survey of all VAMCs and their preparedness for WMD. I plan to review the results and determine where we still need to enhance readiness. I also plan to have all VISN and VAMC contingency plans reviewed to ensure consistency throughout the system.

We have received ongoing guidance in Emergency Management, VA Contingency, VA/DOD Contingency, and the Federal Response Plan from EMSHG—long before 9–11. Additionally, VHA has just completed development of an Emergency Management Guidebook. The Guidebook incorporates many directives and plans and aligns with the new emergency management standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). It also integrates "Comprehensive Emergency Management," a concept that I fully support and that views "disaster" from an all-hazards perspective. By using this approach, we can plan for all events in the same way, saving time and resources.

*Question 24b.* Not only must VA equip its facilities and train its staff to protect themselves and their patients during disasters, but VA medical centers must also be prepared to fulfill obligations to non-veterans under VA's Fourth Mission and the Federal Response Plan. Do you believe that VA medical staff can meet these challenges without overburdening an already strained system? How would you propose to balance the need to maintain VA's medical infrastructure for use during conflicts and disasters with the pressures to eliminate staff and beds?

Answer. Care of Veterans is first and foremost and we will not commit resources outside our system that degrades care of Veterans in any way. Historically, VA has heeded the call for disasters and national crises and will continue to do so. VA has the largest and most comprehensive integrated health care system in the country. The temporary deployment of personnel and resources, therefore, would not have the impact on VA that it might have on other, non-integrated systems. VISNs and VAMCs have well designed contingency plans and have planned for contingencies that would require personnel losses though military deployments or for VA/DoD Contingencies, and that may, therefore, require us to call back retirees and volunteers to back-fill staff and transfer patients among facilities. More importantly, we consistently train, exercise, and evaluate contingency plans in order to recognize where shortfalls may occur.

*Question 24c.* I understand that the new Office of Operations, Security, and Preparedness is still being developed. How would you envision its role in influencing medical preparedness strategies and how would you, if confirmed, work with that office as the Under Secretary for Health?

Answer. I understand that the new Office of Operations, Security, and Preparedness will have oversight for all VA. Its roles will include the evaluation of programs and the issuance of guidance for the Department. It will also represent VA at high level meetings with the new Homeland Security Office and with other department/agency leaders, addressing issues that may include, but go well beyond, health care concerns. I plan to have a positive and effective relationship with the new Office.

I plan to communicate routinely with them about VHA's specific requirements and issues. We all have veterans' best interests as our primary concern and will approach the challenges of Homeland Security as a team.

*Question 24d.* VA can claim resources—including experts in treating post-traumatic stress disorder and local partnerships throughout the Nation—that place it in a unique position to meet the needs of communities overwhelmed during natural or deliberate disasters. Historically, VA's assets have not always been used efficiently during public health crises. How do you propose integrating VA more effectively into the Federal health and medical services planning effort?

Answer. The use of VA assets during public health crises has improved over the past few years, as the Federal Response community has come to realize VA's vast and tremendous resources and expertise. VA assists HHS and CDC in managing pharmaceutical caches and provides training to personnel in hospitals enrolled in the National Disaster Medical System. We have supported every major Presidentially declared disaster beginning with Hurricane Andrew, have provided support for many special events deemed "high risk" by the National Security Council, and have coordinated and delivered many interagency education, training and exercise programs. The area where we need to improve is in having a "seat at the table" with the decision-making bodies. It is critical that VA has an opportunity to be involved throughout the planning process at the highest level. I plan for VHA to be aggressively involved with relevant decision-making groups, e.g. the NDMS Senior Policy Group. I will consistently communicate and interact with those making the decisions that impact VA and the veterans we serve.

*Question 25.* GAO has encouraged expedited implementation of the cook-chill food preparation systems at VA Medical Centers. Do the facilities in VISN 8 have such system. In your view, are there any quality issues related to this type of advanced food preparation?

Answer. GAO recommended that consolidated advanced food production systems (known as cook/chill) be one of the service delivery options that VA facilities consider for improved efficiency, cost savings, and quality patient food service. VHA recommended that VISNs and VAMCs conduct feasibility studies prior to implementing this option in order to address issues of patient satisfaction, cost effectiveness, and cost savings. Several facilities in VISN 8 have consolidated advanced food production and delivery systems, including Tampa, West Palm Beach/Miami, and Bay Pines. The food service operation in Tampa was recognized with a VA Deputy Secretary's Scissors Award for its improved efficiencies, cost savings, and customer satisfaction.

Quality issues certainly can arise in this system as with any system of food production and service. Following are potential positive and negative issues impacting the "cook-chill" system.

POSITIVE

- Greatly enhanced food temperatures for hot and cold temperature retention.
- Greater food safety measures relative to food handling and time/temperature control.
- Greater control of food costs and yield related to Food Production changes.
- Reduced labor requirements in Food Production and service due to ability to cook product in advance and store it for future service, which compresses work schedules.
- Potential for outside revenue streams for food product.

NEGATIVE

- Menu selection can be more restrictive since certain food products do not hold proper texture and appearance when prepared in a cook-Chill system.
- System design requirements for hot and cold side of the meal tray limits size of trays. This in turn limits the number of items that can be provided on each side.
- Human error factors such as putting the tray into the retherm cart backwards where the hot side is chilled and the cold side is heated. This generally impacts on timeliness of meal delivery, as the patient waits until a new tray is made.

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RESPONSE TO WRITTEN POST-HEARING QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO ROBERT ROSWELL, M.D.

*Question 1a.* At some facilities, physicians are being asked to spend less time with each patient in order to see more patient visits and reduce waiting times. Doctors and other direct care providers are also being asked to increase their total patient

caseload. How will you balance the need for VA to reduce wait times for appointments with the needs of doctors and care providers to spend adequate times with their patients?

Answer. VHA has recently adopted a set of standards that will be employed to uniformly measure the number of patients managed within each provider's panel. These standards will allow us to determine those factors associated with a need to spend more time with individual patients, and develop more consistent standards for an optimal provider panel size that balances efficiency with patient needs.

*Question 1b.* What process will set up to ensure that care providers will have input on caseload sizes and length of patient visits?

Answer. I will rely upon advice and counsel from both the VA Chief Consultant for Ambulatory Care and field advisory groups when formulating any policy guidance related to establishing provider panel sizes.

*Question 2.* In a Tampa Tribune article dated February 26, 2002, you are quoted as saying that the VA needs legislative changes to make physician pay more competitive. If you are confirmed, can we expect such a legislative proposal?

Answer. I understand that VA has made recommendations to OPM and OMB concerning the need to increase VA physicians' special pay. I also understand that based on these recommendations, OMB will soon forward a legislative proposal to make certain adjustments in VA physician special pay. Although, I am not aware of the exact nature of the recommended changes, I would likely support this legislative proposal.

*Question 3.* Many VA facilities are considering contracting out fire fighting and prevention to local communities. Even in non-disaster situations, fires at hospitals—which house radioactive materials and many toxic chemicals—are critical and crisis events. By law the Department of Defense is prohibited from contracting out fire prevention just because of the need to maintain in-house first responder capacity in times of natural or deliberate disasters. Will you recommend that VA reconsider its plans to further cutback on VA's in-house fire prevention and hazmat capacities?

Answer. Each decision to eliminate an in-house VA fire department and transfer the fire suppression services to a local community is done with considerable review. We will continue to evaluate each new plan from individual VHA health care facilities when they consider obtaining fire suppression services from the local community. There is no agency mandate for VHA health care facilities to eliminate their in-house fire departments. It is always a local decision. However, the local fire suppression services must meet our minimum criteria before the VA facility phases out their in-house fire department. The closure of 12 of our in-house fire departments over the past 15 years occurred as a result of the community fire departments eventually meeting our fire suppression criteria. Protection is provided by community fire departments for the vast bulk of our health care facilities with only 24 of 172 locations currently provided with in-house VA fire departments. VA has never contracted out with private firms for fire suppression services. A few of our facilities contract with the local communities when the VA facility is not entitled to receive the fire suppression services for free. Our standard protocol when closing an in-house fire department is to offer all fire fighters other positions at the facility, including some fire prevention specialist positions.

All of our facilities with radioactive materials must comply with National Fire Protection Association Standard No. 801, Standard for Fire Protection for Facilities Handling Radioactive Materials along with other pertinent requirements. As a health care provider subject to numerous safety oversights, our facilities are well equipped and trained to address incidents involving hazardous materials, including those where fire suppression services are provided by the local community fire department. VA health care facilities work extremely closely with local communities in coordinating responses to hazardous material incidents and planning for incidents with weapons of mass destruction. The hazmat capability of our health care facilities has expanded dramatically over the past few years and especially since 9/11. Much of this effort has been due to increased Joint Commission on Accreditation of Healthcare Organizations emphasis on emergency management. Those facilities with an in-house VA fire department use our own fire fighters as first responders in coordination with other local fire and emergency forces.

*Question 4.* How does conversion to cook/chill affect VA's ability to provide food and shelter in mass disasters?

Answer. From my personal experience with cook/chill systems in VISN 8, I believe that conversion to this process would enhance disaster capability through the increased capacity and flexibility in preparation afforded by this approach. Emergency/disaster feeding programs are an integral part of VA's healthcare emergency preparedness plans at local VA facilities. Generally, VA emergency plans include

provision for several days of food and supplies and a menu with limited requirements for preparation and service.

*Question 5a.* As you know, I am quite interested in new quality management initiatives that are able to demonstrate good results. Last year, VA physicians at the Tampa VA evaluated a diabetes software management tool that helped guide physicians in the care of veterans with diabetes. The group of diabetic veterans that used the software had enhanced medical care for each of the six clinical diabetes variables measured. Further, the study extrapolated the 38 veterans who tested this software may have saved the VA almost $800,000 in deferred medical interventions. Considering the success of this study, if confirmed, what will you be doing to bring this kind of software to all medical centers, so that patients throughout the system can benefit?

Answer. The software system evaluated at the Tampa VA is one of several efforts to automate clinical practice guidelines. Practice guidelines such as this have been shown to enhance both the quality and efficiency of care provided to patients. Moreover, when guidelines are automated and integrated into an electronic medical records system, their access and utilization by clinicians is greatly enhanced, further increasing these desirable outcomes. I strongly support efforts to integrate clinical practice guidelines into VA's Computerized Patient Record System and will work to assure continued progress towards this goal.

*Question 5b.* There are indications that veterans may be at an increased risk for hepatitis C. Please share your assessment of the status of VHA's hepatitis C programs and note any changes you would make.

Answer. VA is the largest single provider of hepatitis C screening, testing and treatment in the nation. In 1998 VA recognized the need for a concerted, organization response to the problem of hepatitis C infection. The essential components of that response are:

- Identification of those at risk through organized screening activities
- Testing for infection in those with risk factors
- Education and counseling for those with and at risk for hepatitis C
- Education and skill building for providers for care for patients with or at risk for hepatitis C
- Offering the best available therapies for those infected
- Supporting research to improve knowledge about hepatitis C, particularly among veterans.

These are the elements of a comprehensive public health approach. As a result, VA has emerged as a national leader in hepatitis C. During the past three fiscal years (FY 1999–2001), over 1.7 million veterans have been screened for risk factors associated with hepatitis C, over 800,000 blood tests were performed, and over 109,000 veterans had a positive blood test. All FDA-approved therapies for hepatitis C are on the national VA formulary. VA has the only published treatment recommendations that incorporate newest therapeutic advances. Strategic partnerships have been forged with veterans organizations, the pharmaceutical industry, and with other federal agencies. VHA has established a specific program office for hepatitis C and has funded four field-based sites to serve as resources for developing best practice models in screening and testing, education, prevention, and clinical care delivery. Thus, VA is meeting the challenge of hepatitis C with a comprehensive public health approach that has been extremely successful.

Screening at risk veterans for hepatitis C has also been incorporated into VA's performance measurement system, and I understand that we are currently very close to our goal of screening 80% of all patients at risk for this disease. I will continue to monitor our progress and re-evaluate the target goal of 80%.

*Question 5c.* I understand VHA has worked with veterans organizations and other advocacy organizations to educate and inform as many veterans as possible about hepatitis C. Please tell the Committee about these activities and what other activities you envision to better inform veterans about hepatitis C so those who may be at risk can be screened or tested.

Answer. VA has developed effective partnerships with a number of veterans service organizations (VSO's), advocacy groups for veterans with hepatitis C, and other public service organizations to increase awareness of hepatitis C. In addition, VA has developed, initially through the Centers of Excellence program, and now through the Hepatitis C Resource Center program, a wide variety of educational materials in a variety of formats including, print, video, and internet-based communication tools. Collaboration with the American Liver Foundation (ALF) produced educational brochures that will be distributed to over 3 million veterans. If confirmed I will actively support the continuation and enhancement of these programs.

The greatest challenge at this time is to reach veterans in remote areas, those without regular medical care, and those who may not be aware of VA services for

hepatitis C. Through the Vet Center program and the Hepatitis C Community Advisory Board, made up of veterans from across the country, we have heard repeatedly of the need to incorporate veterans groups in these outreach efforts. I anticipate that we will increase our outreach efforts through the Vet Centers, domiciliary units, homeless veterans programs, and through innovative education programs with ALF, Vietnam Veterans of America, American Legion, Veterans Aimed Toward Awareness and other organizations to make sure that the information is available at the right time and in the right place.

*Question 5d.* I understand the American Liver Foundation has offered to partner with VHA to provide home specimen collection and telephone counseling to veterans who may not want to come to a VA facility for hepatitis C testing. Please share with the Committee your perspective on this proposal.

Answer. I believe that all veterans offered hepatitis C testing should be provided with appropriate counseling concerning the implications of the testing and the results. I also believe that the results from any veteran tested for hepatitis C through a VA program should be recorded in the veteran's patient record.

I am somewhat familiar with the American Liver Foundation (ALF) proposal and support the general concept. VA has developed an effective partnership with the ALF and has worked with that organization on a hepatitis C education program that will result in delivering over 3 million informational brochures into the hands of veterans.

I understand that the ALF proposal for telephone counseling and home specimen collection for veterans who were not receiving care at VA facilities was carefully reviewed by VA's hepatitis C program office. VA concluded that the proposal could not be accepted due to concerns about the adequacy of telephone counseling provided by non-VA employees without medical training. There were also serious concerns about the ability to provide adequate follow up for those who tested positive if they were not enrolled in or not eligible for VA care. VA has informed the ALF of this decision and has offered to work with ALF on alternative proposals to improve awareness of hepatitis C and to encourage those at risk to be tested. Discussions between the hepatitis C program office and the ALF are continuing and VA looks forward to continuing this successful partnership.

*Question 6.* The number of inpatient mental health programs have been drastically reduced; some argue that units have been closed without a corresponding increase in supportive outpatient programs. What is your view of this change and, based on your view, what guidance will you disseminate to the field ensuring that an adequate capacity remains?

Answer. Improved treatment approaches and more effective medications have reduced our reliance upon inpatient programs to manage serious mental illnesses. However, veterans lacking adequate social support systems, including homeless veterans, may not be appropriate candidates for non-institutional programs. I will work to see that residential beds are available for this group of veterans, and I will work closely with the Secretary's Special Advisory Committee on Serious Mental Illness to assure that a full range of needed mental health services are available to all veterans.

*Question 7.* Increasingly it seems that under the current network structure, network directors have tremendous autonomy. You have expressed your intention to heighten their responsibilities, such as requiring one or two network directors to monitor certain services, like mental health. Please share your thoughts on why Headquarters' Consultants could not instead be drawn upon to make sure best practices are found and developed across the system. Are you confident that network directors have the impartiality and the program knowledge to make decisions for the entire system?

Answer. My plan to reorganize the National Leadership Board into crosscutting committees responsible for key functional areas across all VISNs will place a Network Director and a Headquarters Consultant or Chief Officer as Co-chairs, of each committee. In this manner, the field operational experience of the Network Director will be augmented by the program knowledge and expertise of the Headquarters program official. This utilization of network directors in national program areas in partnership with Headquarters program officials will bring greater shared leadership and accountability to the system. I believe this will assist VHA in balancing multiple interests, policies, and operational needs, and in making difficult choices where required.

*Question 8.* While non-physician extenders are critical to VA, there currently seems to be a problem with the licensing of Physician Assistants. For years PAs received national certification in lieu of state licenses—which are difficult to obtain for PAs who move around the system so frequently. You stated in your prehearing questions that you believe VA should reverse that long-standing policy and require

state licensure. Please explain your position, notably why national certification is no longer an acceptable standard.

Answer. I stated that I believe requiring licensure is an "appropriate way to ensure the quality of care to our patients. However, we must evaluate any untoward effects that the implementation of this new regulation would have on our workforce and the patients they serve." I agree that current state licensing procedures may make it difficult for some PAs to obtain a license that accurately reflects the nature and scope of their VA practice. This may result in an "untoward effect" that was mentioned in my statement. If this proves to be the case, I would support a waiver mechanism for the PA's affected.

*Question 9.* The recent decision under CARES in Chicago illustrates that the plan is to reduce hospital presence in some areas and redirect those resources elsewhere. This ultimately will lead to reductions in training opportunities for medical residents, as was the case with Northwestern University. Given this decision, how will VA maintain its long-standing and valuable emphasis on teaching?

Answer. The first deployment of the CARES process in VISN 12 is still underway. I am informed that both VHA and Northwestern University continue to work together to plan ways to provide the highest quality of health care for veterans while at the same time maintaining the academic mission of VHA and Northwestern University. All parties are actively seeking creative solutions that will strengthen educational opportunities.

My understanding of the VISN 12 CARES recommendations is that Northwestern will be encouraged to place residents funded through VA at either the outpatient facility to be located at the former Lakeside location or at the renovated Westside location.

VHA recognizes that we must consider many aspects of the academic environment when considering changes in health care delivery. These areas include residency program needs, faculty development, departmental needs, medical student needs, workforce constraints, and accreditation requirements. I strongly support our affiliations with over 100 medical schools and believe we must take a more aggressive approach to involving them in the formulation and evaluation of future CARES service delivery options. The regular participation of these important stakeholders will be actively encouraged.

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RESPONSE TO WRITTEN POST-HEARING QUESTIONS SUBMITTED BY HON. BOB GRAHAM TO ROBERT ROSWELL, M.D.

*Question 1.* What is your view of the CARES system? If this isn't the best method of getting value for VA's health dollar—what is? How do we ensure health care dollars are spent for health, rather than maintenance of facilities?

Answer. In 1999, GAO concluded that VHA could significantly reduce the funds used to operate and maintain its capital infrastructure by developing and implementing market-based plans for restructuring assets. Therefore, VA established the Capital Asset Realignment for Enhanced Services (CARES) program to objectively assess veterans' health care needs within each Network and propose the most effective alignment of assets and related resources to meet the future health care needs of veterans. Such a comprehensive evaluation of a large health care delivery system had never been undertaken before. The Secretary of Veterans Affairs recently announced his decision about the final options for the pilot Phase I conducted in VISN 12. Projected savings throughout VISN 12 over the next 20 years are estimated to be $725 million, which are savings that will be redirected within the VISN for new/expanded health care programs.

Plans are being developed to perform the remaining CARES studies in 20 VISNs simultaneously in Phase II. VA expects that these studies will be completed, reviewed by an external Commission, and that final decisions will be made by the Secretary within the next two years. I believe we have a method through the CARES process to ensure that we are redirecting resources where they are most needed and are improving the quality of and access to VA care.

*Question 2.* Due to Florida's growing veteran population, the wait in VISN 8 for a first time physician visit is often over one year. How do you plan to shorten the waiting period nationwide?

Answer. Lengthy waiting times for new enrollees in Florida and elsewhere in the country are clearly related to a growth in the demand for VA care that has exceeded currently available resources. Although a completely satisfactory resolution of this problem will require additional funds, there is much VA is currently doing to address the issue. Primary care provider panel sizes are being carefully evaluated with a goal to increase the number of veterans to whom each clinician is able to provide

care. Waiting times have been significantly shortened in many areas through a program known as Advanced Access that re-engineers the scheduling process allowing patients greatly increased access to their providers. Extensive management efficiency efforts are underway that will allow existing dollars to be re-directed to address this problem. I will support these and similar programs, while seeking new and innovative approaches to continue to reduce waiting times.

*Question 3.* Some VISNs have a lower volume of patients than others, and thus, lower funding. Yet due to travel or retirement, the veteran population is quite mobile and often needs treatments or physician visits away from their primary VISN region. This is especially prevalent in Florida when the senior, and consequently, the veteran populations grow considerably during the winter months, yet funding remains stable throughout the year. Do you envision ways to unify the distribution of money and care per patient throughout the VA system, rather than directly to the VISN?

Answer. The current VERA model used to distribute funds to each of the VISNs has a mechanism to direct dollars to multiple networks when an individual veteran receives care in more than one network during a fiscal year. This process, involving pro-rated patients, is one of several aspects of the VERA process currently under review to determine if further improvements to the model are needed.

*Question 4.* What is your view as to the adequacy of the VA's response to the high prevalence of hepatitis C among veterans?

Answer. VA is the largest single provider of hepatitis C screening, testing and treatment in the nation. In 1998 VA recognized the need for a concerted, organization response to the problem of hepatitis C infection. The essential components of that response are:

- Identification of those at risk through organized screening activities
- Testing for infection in those with risk factors
- Education and counseling for those with and at risk for hepatitis C
- Education and skill building for providers for care for patients with or at risk for hepatitis C
- Offering the best available therapies for those infected
- Supporting research to improve knowledge about hepatitis C, particularly among veterans.

These are the elements of a comprehensive public health approach. As a result, VA has emerged as a national leader in hepatitis C. During the past three fiscal years (FY 1999–2001), over 1.7 million veterans have been screened for risk factors associated with hepatitis C, over 800,000 blood tests were performed, and over 109,000 veterans had a positive blood test. All FDA-approved therapies for hepatitis C are on the national VA formulary. VA has the only published treatment recommendations that incorporate newest therapeutic advances. Strategic partnerships have been forged with veterans organizations, the pharmaceutical industry, and with other federal agencies. VHA has established a specific program office for hepatitis C and has funded four field-based sites to serve as resources for developing best practice models in screening and testing, education, prevention, and clinical care delivery. Thus, VA is meeting the challenge of hepatitis C with a comprehensive public health approach that has been extremely successful.

Screening at risk veterans for hepatitis C has also been incorporated into VA's performance measurement system, and I understand that we are currently very close to our goal of screening 80% of all patients at risk for this disease. I will continue to monitor our progress and re-evaluate the target goal of 80%.

*Question 5.* In view of the VA's failure to spend appropriate finds for this purpose, do you believe VA management should "fence" these funds as they have for prosthetic and sensory aids in the past?

Answer. In general I oppose "fenced" funds because they can limit the best utilization of dollars and may lead to unspent dollars at the end of a fiscal year.

VA's failure to effectively utilize funds appropriated for hepatitis C care resulted from projections based on a set of assumptions and estimates that were untested at the time. The cost projections forecast by these models were higher than the actual costs recorded in each of several fiscal years. Current cost estimates have been adjusted accordingly, and VA is taking positive steps to measure hepatitis C-related costs and workload more accurately through the development of a national hepatitis C case registry and other automated systems. I believe that we can have a more positive effect on care through the adoption of performance measures, the provision of useful and timely data, and the quality management initiatives of the hepatitis C program office. I am confident that such an approach can be adapted to track hepatitis C care without limiting the best utilization of these funds.

*Question 6.* I believe that you are aware that the American Liver Foundation proposed a significant outreach program that included as a component the use of an

FDA-approved home test kit. Are you familiar with this proposed, and what is your view with regard to its merits?

Answer. I am somewhat familiar with the American Liver Foundation (ALF) proposal and support the general concept. VA has developed an effective partnership with the ALF and has worked with that organization on a hepatitis C education program that will result in delivering over 3 million informational brochures into the hands of veterans.

I understand that the ALF proposal for telephone counseling and home specimen collection for veterans who were not receiving care at VA facilities was carefully reviewed by VA's hepatitis C program office. VA concluded that the proposal could not be accepted due to concerns about the adequacy of telephone counseling provided by non-VA employees without medical training. There were also serious concerns about the ability to provide adequate follow up for those who tested positive if they were not enrolled in or not eligible for VA care. VA has informed the ALF of this decision and has offered to work with ALF on alternative proposals to improve awareness of hepatitis C and to encourage those at risk to be tested. Discussions between the hepatitis C program office and the ALF are continuing and VA looks forward to continuing this successful partnership.

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## RESPONSE TO WRITTEN POST-HEARING QUESTIONS SUBMITTED BY HON. ARLEN SPECTER TO ROBERT ROSWELL, M.D.

### INSURANCE REIMBURSEMENTS

*Question 1.* As you may have heard, during the Budget hearing on February 14 of this year. I suggested to Secretary Principi that he begin disciplining—even firing—physicians and other clinicians who do not properly document their work. If you are confirmed, do you believe that you can take the necessary steps, including severe discipline against your fellow physicians, should this obvious documentation problem continue?

Answer. Physician documentation is one of many critical steps in the revenue cycle where improvements must be made to enhance VA's collections from private insurance companies. I believe we must provide needed education and training for all clinical staff, incorporate certified coders into the patient care areas of our medical centers and clinics, and develop performance monitoring mechanisms that will provide physician-specific performance data. These actions will facilitate the documentation process and allow us to identify under-performing physicians.

To the extent a specific provider does not comply with requirements following necessary education/training and feedback from monitoring efforts, I support specific management actions that would include validating understanding of requirement and determining willfulness of noncompliance. I am prepared to take disciplinary action against physicians identified in this manner who fail or refuse to correct their documentation performance.

*Question 2.* In that same February 14 hearings I asked Secretary Principi to report back to me on his plan for ensuring that physicians are held accountable for proper documentation of medical procedures. His response stated that he believes new performance goals and pay incentives are necessary to modify physician behavior. Do you agree? Do you think new performance goals and pay incentives are the "most effective" tools to use in encouraging physician attention to proper medical documentation? Do you believe that there are steps—other than those identified by Secretary Principi—that need to be taken to improve documentation by clinicians? If so, please describe the steps you would recommend.

Answer. I agree with Secretary Principi that performance goals and pay incentives are effective means to change physician behaviors. However, another highly effective way to alter clinical behaviors is providing physicians with feedback on individual performance. Therefore, we must develop monitoring mechanisms that provide physician-specific data. This information, coupled with proper education and training, compliance monitoring, and the placement of certified coders in patient care areas should greatly enhance physician documentation performance. These steps will also allow us to accurately identify high performing physicians for pay incentive purposes, and low performing physicians for remedial purposes. To the extent the proper information and tools are available to all staff involved in the billing process, formal disciplinary action should be an action of last resort.

*Question 3.* VA's Inspector General issued a report at the end of February that said that VA would have collected over $500 million more in third-party receipts had VA implemented and followed previous IG recommendations. Do you agree with

the IG's assessment? If you are confirmed, will you implement all of the recommendations made by the IG in this most recent report?

Answer. The revenue cycle is an extremely complex process that involves numerous steps. Maximum performance can only be obtained with a strong leadership commitment and a comprehensive analysis of each step of the cycle with careful attention to improvement opportunities. Although I am not familiar with how the IG calculated lost revenues, I agree that the VA collection potential is significantly greater than current receipts. If confirmed, improvement across the entire revenue cycle will be one of my highest priorities. I will carefully examine each of the IG's recommendations, along with other recommendations contained within the VA Revenue Cycle Improvement Plan, and will consult with industry experts to assure that our efforts to improve the process leave no opportunity untouched.

*Question 4.* The same IG report noted that VA timeliness in preparing and sending out bills to insurance companies is getting worse—not better. The IG stated that, in the private sector, the average time to send a bill for reimbursement is 10 days, whereas, in VA, the time is approximately 95 days. What steps can you rake immediately to at least reverse the direction of this statistic and bring the times closer to those in the private sector?

Answer. VHA is nearing completion of an Electronic Data Interchange (ED[) that will allow bills to be transmitted directly to third-party insurers, thereby greatly reducing the billing lag time. If confirmed, I will assure that this software is distributed and implemented as quickly as possible throughout all VHA facilities.

BUDGET ISSUES

*Question 5.* Secretary Principi has stated, in effect, that VA is a victim of it's own success and that it is now being overrun by patient demand. The Secretary recommended that Congress charge a $1500 deductible to veterans making just over $24,000 annually to retard demand. Do you believe that there are other alternatives to the $1500 deductible proposal that the Committee should consider to help VA manage increased patient demand? Was your experience with increases in patient population in Network 8 over the past several years similar to the experience Secretary Principi relayed to the Committee?

Answer. Over the past several years, the number of veterans receiving care through VISN 8 facilities has grown by an astounding 80 percent. During this same time period the VISN 8 budget has grown by only 40 percent. Obviously, this growth cannot continue without a substantial increase in funds, if we are to maintain our current high standards of quality and access to care. For this reason Secretary Principi has proposed a $1500 deductible for priority seven veterans, although he has stated that he is willing to consider other alternatives. Unfortunately, the alternatives to imposition of the deductible are few. We must either limit enrollment, or reduce the level of services provided to enrolled veterans, or supplement the current medical care budget with additional funds from either appropriated or non-appropriated sources, such as Medicare.

*Question 6.* In recent testimony before the Senate VA–HUD Appropriations Subcommittee, Secretary Principi stated that VA's financial difficulties were due, in large part, to "unfunded mandates" imposed by Congress on VA. As a network director, did you find that your budget was severely hampered by having to absorb "unfunded mandates" from Congress? What are some examples of the unfunded mandates Secretary Principi spoke of in his testimony last week?

Answer. A number of factors including increased workloads and unfunded mandates have made it difficult to meet patient needs and expectations in VISN 8. As a Network Director, some of the programs that have been mandated in recent years without specifically identified funds include a requirement to increase staffed nursing home care unit beds, a requirement to provide mental health services in community based primary care outpatient clinics, a requirement to enhance opioid-replacement programs, a requirement to provide life-long nursing home care to veterans with 70 percent or greater service-connected disabilities, a requirement to provide home and community care services to all enrolled veterans in need of such care, and, specific to VISN 8, a requirement to provide community-based contract hospital care to veterans residing in East Central Florida.

*Question 7.* Following enactment of so-called Eligibility Reform legislation, VA began a significant effort to recruit new patients into the system. VA opened hundreds of outpatient clinics, and made the decision to accept all categories of enrollees (1–7). How many patients were enrolled for VA health care when you assumed the position as director of VISN 8? How many are enrolled today? Isn't it fair to say that the increase in VISN 8—and VA-wide—enrollment is a direct result of these extensive outreach and patient-enrollment efforts?

Answer. When I became the VISN 8 Director in early 1996, there were approximately 225,000 veterans receiving care from VISN 8 facilities. Today that number has risen to over 410,000. This tremendous increase in users has certainly been facilitated by the opening of a number of community based outpatient clinics, coupled with a national enrollment policy allowing all veterans to receive VA care. However, I believe there are several other factors contributing to this growth. These include the general economic conditions within the United States, the failure of a number of Medicare HMOs, lack of a Medicare prescription drug benefit, and a growing recognition that VA now provides extremely high quality medical care. Additional factors that may be specific to VISN 8 and Florida include a historical inability to provide care to lower priority veterans, creating a very large suppressed demand for care; and the large number of veterans who continue to relocate to Florida.

*Question 8.* The "VERA system" of resource allocation has run a painful course for a few of the networks in the northeast. Some, like Network 4 (Pennsylvania) have become extremely efficient operations and have absorbed significant financial stress without running a deficit. Others—such as Network 3 (New York City) have repeatedly exceeded their allocated budgets—and have been "bailed out" with supplemental funding at the expense of other networks. What will you do to assure that efficient, successful networks do not continue to subsidize the inefficient and unsuccessful practices of other networks?

Answer. Supplemental funds may be required by a VISN for a number of reasons, including catastrophic events, irregularities within the VERA system that fail to adjust for regional variations in labor and contract costs, aging facilities that are more expensive to maintain, and the presence of high cost programs that may not exist in other networks, as well as management inefficiencies. If confirmed, I will continue to evaluate the VERA allocation model and adjust it as necessary to correct these deficiencies. I will also take aggressive steps to reduce management inefficiencies in all VISNs through a revised performance measurement system, the use of budget execution and financial management monitors, and the creation of a finance committee within the VHA National Leadership Board, charged to improve management efficiencies across all of the 21 networks.

NATIONAL EMERGENCY PREPAREDNESS

*Question 9.* In his testimony before this Committee on February 14, 2002, Secretary Principi stated that VA should play a more significant role in the nation's domestic preparedness efforts. Do you agree with the Secretary's view?

Answer. I strongly support the Secretary's position on the role of the VA in domestic preparedness efforts. I believe there is no better-situated integrated healthcare system to provide emergent care in the event of a domestic terrorist action than the VA. In addition to over 800 locations of care throughout the nation, VHA employs a workforce of over 185,000 including more than 12,000 physicians. A vast communications network, which includes a comprehensive electronic medical record system, and a digital satellite network connect this extensive network of facilities and clinicians. Collectively, these features virtually assure that VA care will be available in a time of need, and the necessary education, training, and communications to assure both preparation and response can be readily provided.

*Question 10.* What actions do you believe VA should take to prepare itself better—and to prepare the Nation better—to respond to a large-scale disaster like that which occurred in New York, Pennsylvania, and Virginia in September? How much money does VA need to prepare itself, and others in our Nation's communities, to respond to a large-scale disaster? And how much are you devoting to that process now?

Answer. VA must first prepare itself to ensure continued care for VA patients, viability of facilities, and protection of staff. In this regard we are implementing a program of education, training, decontamination capability, and supplementing pharmaceutical inventories with special caches. Secondly, VA has determined a need for a more resourced and focused approach to coordinate and execute its mission to respond as a key support agency during national emergencies, To this end, VA is developing a new office of Operations, Security, and Preparedness, which will report to the Deputy Secretary and work closely with the Office of Homeland Security. Finally, VA must strengthen relationships with the many communities in which we reside, through mutual support and the maintenance of a high degree of readiness. We are doing this through our network of Area Emergency Managers in every VISN.

In the current Fiscal Year (FY2002) we have devoted $22M to the VA pharmaceutical caches, $156,266 to the initiatives of the Emergency Management Strategic Healthcare Group (EMSHG), $146,000 to Continuity of Operations (COOP), and

slightly more than $22M to Critical Infrastructure Protection (CIP). Required additional resources are ongoing and evolutionary as VA progresses in identifying and quantifying requirements. I am not able to predict what these costs would total, but I will actively pursue this agenda if confirmed.

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RESPONSE TO WRITTEN POST-HEARING QUESTIONS SUBMITTED BY HON. BEN NIGHTHORSE CAMPBELL TO ROBERT ROSWELL, M.D.

*Question 1.* As you are aware, I have been very supportive of an innovative proposal which, if implemented, will provide veterans in Colorado and the nation with state of the art health care facilities at the site of the former Fitzsimons Army Medical Center. I have two questions: Would you comment generally on your attitude about seeking new and creative ways to align with other organizations to deliver high quality health care to America's veterans? And, will you, if confirmed, work to bring this precedent-setting project to fruition?

Answer. I am very interested in working to enhance the efficient delivery of high quality healthcare service to veterans in new and innovative ways, including partnering with other healthcare providers and institutions. During my tenure in Florida, I was able to establish innovative programs to enhance veterans care through arrangements with Florida State Veterans Homes, the U.S. Navy, private community healthcare facilities, and several of our affiliated medical schools. I am familiar with the proposal to enhance veterans' care at the former Fitzsimons location, and I understand that numerous meetings have been held with veterans service organization representatives and employee union representatives to discuss the potential options and progress in making a definitive recommendation to the Secretary. A consultants report outlining the costs and benefits of several potential options for the VA Denver facility is due in mid-April. The recommended course of action will then be determined. If confirmed, will actively explore ways this project could be brought to completion.

*Question 2.* The VA is already experiencing a doctor and nurse shortage. According to some of the vets in Colorado, it takes six months to get a regular medial appointment and for veterans with spinal cord injuries and multiple sclerosis, there is an 18 month waiting period for an annual checkup! What plans would you put in place to address this personnel shortage?

Answer. We are currently experiencing a national shortage of nurses and physicians in certain specialty areas. I believe VA's efforts to recruit and retain needed clinicians during this shortage must be multi-faceted. We do not have the flexibility to respond as quickly to competition in the job market as do private sector entities. Therefore, we must explore financial incentives including recruitment bonuses, enhanced salary rates, an expanded special pay authority for physicians, and loan and tuition reimbursement programs. However, success in this area will also depend on creating a rewarding and stimulating setting where clinicians are able to achieve their full practice potential aided by the latest innovations in technology and health care delivery. We must also continue to support our research programs and academic affiliations that have consistently helped VA recruit and retain outstanding clinicians.

*Question 3.* As our veterans' population ages, long term care will become a more and more important part of VA services. How would you, if confirmed, address the increased needs for long term care? Are you in a favor of a voucher system?

Answer. If confirmed, I will actively work to develop a full continuum of long-term care and end of life services. In addition to existing VA, State Home, and contract nursing home beds, I will work to expand community and home care programs and services as I have done in VISN 8. We have shown that by using interactive technology to coordinate care and monitor veterans in the home environment, we are able to significantly reduce hospitalizations, emergency room visits, and prescription drug requirements, while improving patient satisfaction with the care they receive. This approach not only reduces the need for institutional long-term care, but provides veterans with a more rewarding quality of life and greater functional independence. Because I believe that VA is positioned to provide a higher quality of long-term care at lower cost than non-VA providers, I do not favor a voucher system.

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RESPONSE TO WRITTEN POST-HEARING QUESTIONS SUBMITTED BY HON. LARRY E. CRAIG TO ROBERT ROSWELL, M.D.

*Question 1.* In your opening statement you talk about the need to maximize performance and to minimize variation across the 21 VISNs via a strategic planning process. How long do you anticipate this process taking?

Answer. My plan to improve performance and reduce variance across the current 21 VISNs involves a restructuring of the National Leadership Board, which consists of all VISN Directors and Chief Officers from VA Central Office. By reorganizing the board into crosscutting committees with responsibilities for key functional areas across all VISNs, our most senior executives will become responsible for performance results across the entire system instead of just within their own network. The plan also calls for a comprehensive strategic planning process and alignment of performance measures to reflect the highest VHA priorities identified through the planning process. Performance contracts with individual VISN Directors will reflect both network priorities and system priorities addressed through the crosscutting committees. The implementation plan for this reorganization is nearly complete and I expect to have it in place within 60 days after my confirmation.

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RESPONSE TO WRITTEN POST-HEARING QUESTIONS SUBMITTED BY HON. KAY BAILEY HUTCHISON TO ROBERT ROSWELL, M.D.

GULF WAR ILLNESS

*Question 1.* Were you involved in conceiving the stress theory of Gulf War syndrome? What was the basis for it? Do you still believe that stress plays a major role in the illnesses? Should treatments for stress be a main part of treating Gulf War veterans?

Answer. I was not involved in either the formulation or promulgation of a hypothesis that Gulf War illnesses were a result of combat stress. In fact, I coauthored a paper that contrasted the symptoms of Gulf War illnesses with those typically associated with stress. However, I do believe that stress can co-exist and even aggravate any chronic debilitating illness, including those seen in veterans of the Gulf War. I have also been personally involved in the care of a number of veterans who experienced PTSD symptoms in addition to Gulf War illnesses. Therefore, I believe that stress management or treatment should be an available treatment modality in any comprehensive approach to managing the health of Gulf War veterans.

*Question 2.* What was your role on the PGVCB (Persian Gulf Veteran Coordination Board)? Why has the research funded by PGVCB failed to show important causes for Gulf War syndrome?

Answer. I served as the Executive Director of the Persian Gulf Veterans Coordinating Board (PGVCB), whose membership was limited to the Secretaries of Defense, Health and Human Services, and Veterans Affairs. In this role, I was responsible for coordinating the activities of the support staff assigned to the board. Research was never funded directly by the Board, although the Board undertook activities to coordinate and compile research activities funded by the three participating Cabinet Agencies.

*Question 3.* What research experience have you had? How many research papers (not editorials and commentaries) have you published? Do you feel that you understand the research process well enough to lead the VA research program?

Answer. My personal research experience as a funded investigator is limited to the earlier part of my VA career and I have published only approximately a dozen "research papers". However, as a member of the faculty of four medical schools, including the University of Texas at Southwestern, and as an experienced clinical administrator, I have extensive experience in oversight and support of research programs. I have also served on national boards and committees with research oversight responsibility and have been invited to serve as a reviewer for a number of journals that publish research papers. This breadth of experience has given me a thorough understanding of the research process, which I believe makes me well qualified to provide administrative oversight for the VA research program.

*Question 4.* Why did PGVCB never fund creative research approaches that ultimately proved successful, such as the UT Southwestern work? Would you now be more supportive of researchers who are making positive contributions?

Answer. As mentioned above, no research was directly funded by the PGVCB. However, my experience with the Board has taught me that we must carefully consider both traditional and non-traditional approaches to the diagnosis and management of what are still poorly understood disease processes observed in veterans of the Gulf War. Accordingly, I would support such investigative efforts when peer review has validated the merit of the scientific principles employed in the proposed studies.

*Question 5.* Currently, one of the big problems in research on Gulf War syndrome is obtaining honest, accurate statistical analyses of the existing DoD and VA databases. We are told that they are too fragmented t put the complete picture together

to show how many are sick, and why. Would you be in favor of creating a master computer database by combining all the DoD and VA databases and letting impartial analysts analyze it?

Answer. I am very much in favor of sharing and, where possible, combining information from both VA and DoD databases. This was a key principle upon which the PGVCB was established and I still strongly support this premise. There are some significant differences between the two registries that create technical challenges when this type of merger has been attempted. However, if confirmed, I would work to increase access to the combined registries by qualified scientific scholars.

*Question 6.* The President's FY'03 VA budget submission does not contain a request fro peer-reviewed medical research for Gulf War Illness. Do you think research of any value could be conducted if even a few million dollars funds were available? Would you support Congressional efforts to add money specifically for that purpose?

Answer. Although the President's FY'03 budget request does not specifically seek funds for Gulf War Illnesses, I believe the level of the request for VA intramural research should be sufficient to allow funding of meritorious work in this area. However, I am generally opposed to fencing funding for a specific purpose, because such efforts cannot assure the scientific merit of the work that receives funding. I believe that competitive peer review of requests for research funding adds value and scientific rigor to the work that ultimately results.

DVA/DOD COOPERATION

*Question 7.* I am convinced that the missions of our DoD and VA hospitals can be best achieved with enhanced cooperation and integration between the two systems. Dr. Roswell, would you please tell me your vision for accomplishing this?

Answer. I fully agree that enhanced cooperation and sharing between DoD and VA will benefit both healthcare systems and the patients they serve. If confirmed, I will pursue this initiative through my full support of the activities of the Presidential Task Force on VA and DoD Sharing. In addition, I will actively support and participate in the recently revitalized Health Executive Council between the two Departments. I will also draw upon my personal experiences on both active military duty and in the military reserves to support this effort.

DALLAS MENTAL HEALTH FACILITY

*Question 8.* I am very concerned over the deteriorating state of the Dallas VA Mental Health facilities. In spite of being regarded as a high priority project for years, recent changes in the VA's process for evaluating construction projects has once again left this critical facility high and dry. Can you give me your vision for improving the condition of the VA's critical treatment facilities?

Answer. Although, I cannot speak directly to the status of the Dallas Mental Health facilities, I will fully investigate this concern if confirmed. However, VA currently operates an extensive number of facilities where advanced age and insufficient renovation and modernization funding over a period of years has rendered them ill-suited for the delivery of today's healthcare services. I fully support Secretary Principi's efforts to carefully evaluate VA's capital assets and study how they can best be used to meet the current and future needs of America's veterans. I believe this effort, when complete, will provide VA with a blueprint to determine how available construction dollars can best be utilized to modernize facilities such as those in Dallas.

Chairman ROCKEFELLER. Thank you, Dr. Roswell.

Mr. Cooper.

## STATEMENT OF DANIEL L. COOPER, NOMINATED TO BE THE UNDER SECRETARY FOR VETERANS BENEFITS, DEPARTMENT OF VETERANS AFFAIRS

Mr. COOPER. Mr. Chairman, I am deeply honored to be here today before this committee as a nominee for this particular position, which I consider extremely important to our veterans.

In mid-April of 2001 the Secretary of Veterans Affairs, Anthony Principi, asked that I chair a study focused on methods to improve the veterans' benefits claims processes. We did that. We had 12 people on that committee 12 very knowledgeable people from var-

ious facets of VBA. In October our Task Force reported out to the Secretary and subsequently reported to congressional committees over here.

If I were to presume to tell you what should be done, I would point to this particular Task Force report. It lays out a plan. It lays out things that need to be done. It has 34 recommendations and 66 actions, all of which impact how we do business.

The report is serving now, and will continue to serve, as a blueprint for action and it is being implemented. The Secretary looked at it very carefully about 2 months after we reported out. He made decisions on what he wanted us to do and, with some minor modifications, he accepted the Task Force report.

During my short involvement in VA I obviously was deeply immersed in the Compensation and Pension claims process. However, I want to assure you that I am fully aware of the other very important programs that we have Education, Loan Guaranty, Insurance and Vocational Rehabilitation.

I respectfully request that my full statement be entered into the record and I stand by to answer your questions.

Chairman ROCKEFELLER. Thank you, sir, very much.

[The prepared statement of Mr. Cooper follows:]

PREPARED STATEMENT OF DANIEL L. COOPER, NOMINATED TO BE THE UNDER SECRETARY FOR VETERANS BENEFITS, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman, I am honored to appear before your committee as the nominee for Under Secretary for Veterans Benefits, Department of Veterans Affairs.

In January 1991, I completed a 33½-year career in the United States Navy primarily with the submarine force. Since retirement, I have been involved in industry, participating in several submarine studies, advising for two University Laboratories and serving as a board director for the USAA and later for EXELON Corporation.

In mid-April 2001, the Secretary of Veterans Affairs, Anthony J. Principi, asked that I chair a study focused on methods to improve the veterans' claims processes in the Veterans Benefit Administration. He desired that the entire range of available Secretarial authority, which could address the backlog problem, be reviewed and appropriate action be recommended. He chartered the Task Force to focus on those changes that he could execute quickly—those actions that he could require immediately in order to precipitate a dramatic and immediate impact to mitigate the claims backlog problem. In October, our Task Force reported to the Secretary and subsequently to Congressional staff and the VSO community.

If I were to presume to tell you what needs to be done, I would start with our Task Force report. The report is serving now, and will continue to serve as the blueprint for action. The recommendations have been fully reviewed by the Secretary and ordered implemented with minor modification. Finally, the acting Under Secretary and the acting Deputy have moved expeditiously to implement the recommendations.

I assure you that the philosophy expressed in the first several pages of the Claims Processing Task Force Report is one I strongly espouse. It emphasizes accountability, integrity and professionalism. Those principles are sacrosanct and I know of no other way to operate.

Some people who have reviewed the Task Force Report have implied that, with the dual emphasis of reducing the backlog and decreasing the time delays, we had somehow denigrated "quality". I desire to disabuse anyone of such a notion. The entire report speaks to quality. The quality of response and service to veterans is predicated on a timely, accurate, well stated and consistence process. Every recommendation made by our study—be it the "triaging" of claims, the quest for improved medical exam processes, or the BVA processing of appeals and remands—is based on being consistent, improving quality and providing timely decisions.

Further, I want to assure you I have sampled enough of the VBA organization, both in headquarters and in the field, to be convinced that there is a strong cadre of superb, dedicated, and enthusiastic people in the Veterans Benefit Administration.

During my short involvement with VA, I have been immersed in the Compensation and Pension programs. However, I am becoming more familiar with the four other very important programs overseen by VBA: Education, Loan Guaranty, Vocational Rehabilitation and Employment and Insurance.

The VA Education Program has been a major contributor to the success of the United States since WW II. The GI BILL and its successors have educated more than 21 million beneficiaries since 1944. The goals in Education must be to reduce the claims backlog in this program and to improve the timeliness of response. A priority must be to implement properly the recent legislation expanding education benefits in the areas of "hi-tech" courses and in benefits transferability.

Vocational Rehabilitation provides services and assistance to enable veterans with service-connected disabilities to obtain and maintain suitable employment. Over 10,000 veterans achieved rehabilitation status last year. VocRehab must continue to enhance services to our most seriously disabled veterans and to achieve employment as an outcome during periods of economic uncertainty.

The Loan Guaranty Program guaranteed over 250,000 loans in FY 2001. This program continues to offer "no downpayment" home loans to veterans and to provide an attractive option to veteran buyers. I have been made aware of the challenge in the program to successfully execute the field restructuring effort that is underway. This includes consolidating the Construction and Valuation function from 45 offices to 9, completing the A–76 cost comparison study of the property management function and implementing its outcome, and finishing the comprehensive redesign of the Loan Administration function. Each of these is vital to our veteran population; knowledgeable oversight is mandatory.

Recently, I had the opportunity to visit the Insurance Service in Philadelphia and learn of the tremendous success of this program. Obviously I would do all I could to support their continued success.

Finally, let me assure you that my intention, if confirmed, is to identify the best personnel I can for advice and implementation, and to visit Regional Offices in a methodical but comprehensive manner. I desire to leave no doubt in the mind of every VBA employee, of both the gravity of the "backlog" problem and the direction in which VBA must go to attack it. If it becomes necessary to make "mid-course changes" (in the process or in the plan) the emphasis will always be to do what is best to serve the veteran. And every action must be taken to ensure all the programs are given the priority necessary to be successful.

I can not emphasize too strongly the importance of working closely with the Veterans Service Organizations. We had VSO representation on our Task force and the both the TF and I, personally, met with various VSO representatives. I have also met with VSO representatives when I have visited Regional Offices, and would continue to do so if I were to be confirmed. A professional partnership must be maintained and strengthened as we move forward in the difficult job ahead.

I look forward to working with Congress, your committee and your staff to serve our veteran population the very best way possible.

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UNITED STATES OFFICE OF GOVERNMENT ETHICS,
*Washington, DC, February 15, 2002.*

Hon. JOHN D. ROCKEFELLER IV,
*Chairman, Committee on Veterans' Affairs,*
*U.S. Senate,*
*Washington, DC.*

DEAR MR. CHAIRMAN: In accordance with the Ethics in Government Act of 1978, I enclose a copy of the financial disclosure report filed by Daniel L. Cooper, who has been nominated by President Bush for the position of Under Secretary for Benefits, Department of Veterans Affairs.

We have reviewed the report and have also obtained advice from the Department of Veterans Affairs concerning any possible conflict in light of its functions and the nominee's proposed duties. Also enclosed is a letter dated February 6, 2002, from the agency ethics official, outlining the steps which Mr. Cooper will take to avoid conflicts of interest. Unless a specific date has been agreed to, the nominee must fully comply within three months of his confirmation date with the actions he agreed to take in his ethics agreement.

Based thereon, we believe that Mr. Cooper is in compliance with applicable laws and regulations governing conflicts of interest.

Sincerely,

AMY L. COMSTOCK,
*Director.*

QUESTIONNAIRE FOR PRESIDENTIAL NOMINEES

PART I: ALL THE INFORMATION IN THIS PART WILL BE MADE PUBLIC

1. Name: Daniel Leander Cooper.
2. Address: 121 Leisure Court, Wyomissing, PA 19610.
3. Position to which nominated: Under Secretary for Benefits, Department of Veterans Affairs.
4. Date of nomination:
5. Date of birth: May 21, 1934.
6. Place of birth: East Liverpool, OH.
7. Marital status: Married.
8. Full name of spouse: Betty Jane Ogilvie Cooper.
9. Names and ages of children: Amy Louise Hughes and Cynthia Jane Rose.
10. Education: Institution (including city, state), dates attended, degrees received, dates of degrees:

East Liverpool H.S., East Liverpool, OH; Aug 48–Jun 52; HS; 6/52.
Washington & Jefferson College, Washington, PA; Aug 52–Jun 53; None; NA.
US Naval Academy, Annapolis, MD; Jul 53–Jun 57; BS; 6/57.
Harvard University, Littauer School of Public Administration, Cambridge, MA; Aug 62–Aug 63; MPA; 6/63.

11. Honors and awards: List all scholarships, fellowships, honorary degrees, military medals, honorary society memberships, and any other special recognitions for outstanding service or achievement:

Distinguished Service Medals (3); Legion of Merit (2); and Meritorious Service Medal (4).

12. Memberships: List all memberships and offices held in professional, fraternal, business, scholarly, civic, charitable, and other organizations for the last 5 years and other prior memberships or offices you consider relevant:

Naval Submarine League; President; 6/97–6/01.
Boys Scouts (Hawk Mt. Council); Executive Board; 6/92–Present.
YMCA of Rdg & Berks Co.; Board of Directors; 8/94–Present.
Torch Club of Reading; None; 1996–2/02.
National Defense Industrial Association; None; 1995–2/02.
World Affairs Council of Rdg, PA; Board of Directors; 1997–2/02.
Rotary; None; 1995–Present.
Navy League; None; 1991–Present.

13. Employment Record: List all employment (except military service) since your twenty-first birthday, including the title or description of job, name of employer, location of work, and inclusive dates of employment:

Special Asst to CEO Alex Smith; Gilbert Assoc.; Reading, PA; 3/91–1/92.
VP & GM, Nuclear Services; Gilbert & Commonwealth; Rdg, PA; 11/92–8/94.
Consultant—Primarily studies on Navy Submarines; 8/94–1/02.
Board Member:
- Navy Federal Credit Union; 1982–1988.
- USAA; 1988–1998.
- PECO Utility; 1999–2000.
- Exelon Utility; 2001–Present.
- META 4; 1999–2001.
- HJW Inc; 1999–2001.

14. Military Service: List all military service (including reserve components and National Guard or Air National Guard), with inclusive dates of service, rank, permanent duty stations and units of assignment, titles, descriptions of assignments, and type of discharge:

US Navy from graduation from the Naval Academy as an Ensign to retirement as Vice Admiral in 1991. Primarily on submarine, budgetting and programming Billets.

06/57–12/58; Ensign; USS *Chilton* (APA 38); Junior Officer.
12/58–06/59; JG; Sub School (NLON); Student.
06/59–06/62; LT; USS *Trigger* (SS564); Junior Officer.
08/62–08/63; LT; Harvard; Student.
09/63–07/64; Nuclear Power School; Student.
08/64–12/64; Bettis Atomic Lab; Student.
12/64–12/65; LCDR; Haddo (SSN 604); OPS Officer.
01/66–06/66; DAM Neck (XO School); Student.
07/66–07/68; USS *Simon Bolivar* (SSBN642); XO.
07/68–12/70; CDR; Aide to VCNO—Washington; Aide.
01/71–12/71; Various ships and school; Student.

01/72–03/74; USS *Puffer* (SSN 652); Command.
03/74–06/74; Puget Sound Shipyard; CSP REP.
06/74–06/76; CAPT; Assistant Secretary of Navy; Executive Asst. Commander.
07/76–07/79; Submarine Squadron Ten.
08/79–06/80; RADM; OP Nav—Trident Coordinator.
06/80–06/83; Controller Naval Sea Systems Command.
06/83–10/85; Director, Navy Budgets and Reports.
10/85–08/86; VADM; Director, Navy Program Planning.
08/86–08/88; Commander, Submarine Force; US Atlantic Fleet.
09/88–01/91; Assistant CNO for Undersea Warfare.

15. Government experience: List any advisory, consultative, honorary, or other part-time service or positions with Federal, State, or local governments other than listed above:

April 01–Oct 01; Chairman, Sec VA Task Force on Claims Processing.
Since Oct 01; Implementation Oversight Consultant.
Spring 1995–Fall 2000 served as member of Naval Research Advisory Committee (NRAC) which studied subjects of interest to Navy Research.

16. Published writings: List titles, publishers, and dates of books, articles, reports or other published materials you have written: None.

17. Political affiliations and activities

(a) List all memberships and offices held in and financial contributions and services rendered to any political party or election committee during the last 10 years: No offices. Member of Republican Party.

(b) List all elective public offices for which you have been a candidate and the month and year of each election involved: None.

18. Future employment relationships

(a) State whether you will sever all connections with your present employer, business firm, association, or organization if you are confirmed by the Senate: Yes.

(b) State whether you have any plans after completing Government service to resume employment, affiliation, or practice with your previous employer, business firm, association or organization: No.

(c) What commitments, if any, have been made to you for employment after you leave Federal service? None.

(d) (If appointed for a term of specified duration) Do you intend to serve the full term for which you have been appointed? Yes.

(e) (If appointed for indefinite period) Do you intend to serve until the next Presidential election? N/A.

19. Potential Conflicts of Interest

(a) Describe any financial arrangements, deferred compensation agreements, or other continuing financial, business, or professional dealings which you have with business associates, clients, or customers who will be affected by policies which you will influence in the position to which you have been nominated:

Have a normal blanket agreement with Exelon which states whenever a Director departs he or she will receive deferred compensation previously earned, distributed as agreed at least four months prior to separation.

(b) List any investments, obligations, liabilities, or other financial relationships which constitute potential conflicts of interest with the position to which you have been nominated: None.

(c) Describe any business relationship, dealing, or financial transaction which you have had during the last 5 years, whether for yourself, on behalf of a client, or acting as an agent, that constitutes as potential conflict of interest with the position to which you have been nominated: None.

(d) Describe any lobbying activity during the past 10 years in which you have engaged for the purpose of directly or indirectly influencing the passage, defeat, or modification of any Federal legislation or for the purpose of affecting the administration and execution of Federal law or policy: None.

(e) Explain how you will resolve any potential conflicts of interest that may be disclosed by your responses to the above items. (Please provide a copy of any trust or other agreements involved.)

I will resign from Exelon, have severed all other potentially conflicting arrangements.

20. Testifying before the Congress

(a) Do you agree to appear and testify before any duly constituted committee of the Congress upon the request of such committee? Yes.

(b) Do you agree to provide such information as is requested by such a committee? Yes.

RESPONSE TO PREHEARING QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO DANIEL L. COOPER

*Question 1.* If confirmed, you will assume the position of Under Secretary for Benefits at an extremely crucial time. Please describe in order of importance, what you see as the major problems facing VBA and briefly outline your plans for addressing each, with milestones that you expect to reach.

Answer. For the past eleven months I have served as the Chairman of the Claims Processing Task Force and have been deeply engaged in the analysis of VBA's management of the claims process and in the subsequent development and implementation of the Task Force recommendations. That experience has given me an understanding of the issues and problems facing VBA and their potential solutions, at least within the Compensation and Pension Program. It is clear that the top priority, as expressed so often to me by the Secretary, is to reduce the claims backlog, including appeals, while maintaining rigorous quality standards. With the decline in the backlog and as old cases are removed from the inventory, VBA will begin to improve its processing timeliness. Our plan has been well documented in the Task Force Report, which contains 34 recommendations with 66 actionable tasks. Appropriate milestones have been established for each task and implementation is being tracked in VBA's Project Management System. Seven of the 66 tasks have been completed and another 13 are scheduled for completion within the next 6 months. The challenge for me will be to maintain the momentum that the Acting Under Secretary has created in quickly moving forward with the implementation of the Task force recommendations and, at the same time, immerse myself in the issues facing VBA's four other programs.

I have been made aware of the challenge in the Loan Guaranty Program to successfully execute the field restructuring effort that is underway. This includes consolidating the Construction and Valuation function from 45 offices to 9; completing the A–76 cost comparison study of the Property Management function and implementing its outcome; and finishing the comprehensive redesign of the Loan Administration function. VBA has recently been successful in completing similar initiatives in this program and, if confirmed, I expect to be successful with these.

In Education, like in the C&P Program, I believe the main focus must remain on reducing the claims backlog and providing timely service. The other priority is implementation of the recent legislation that expanded education benefits in the areas of "hi-tech" courses and benefits transferability. In the Vocational Rehabilitation and Employment Program, VBA must continue to focus on enhancing services to the most seriously disabled veterans and achieving employment as an outcome during periods of economic shifts.

Recently I had the opportunity to visit the Insurance Service in Philadelphia and learn of the tremendous success of this program. Obviously, I would do all I could to support their continued success.

*Question 2.* What is your opinion of having outbased decision-making teams from regional offices stationed at military facilities, VA medical centers, or dispersed throughout their jurisdiction for access by geographically dispersed veterans? If you support this endeavor, what kind of resources would be needed to support its continued success (e.g. technology, training, support from the VSO community, and the like)?

Answer. The Claims Processing Task Force was advised that the Benefits Delivery at Discharge (BDD) program is active at 128 military sites, with outbased claims processing teams at 38 of these sites. The Task Force concluded that the BDD initiative is a highly successful and absolutely necessary outreach program for serving new veterans. The medical examination protocols used at these sites allow VBA to evaluate the disabilities claimed without requiring additional examinations after separation. As a result of the services provided by the VBA staff at the separation sites, a complete "ready-to-rate" claim is forwarded to the regional offices or processed to completion at the separation site. Most of these claims are processed within 30 days of the service members' separation from the service.

The Task Force was also informed that only a very limited number of regional offices have a Rating Veterans Services Representative (RVSR) presence at VA medical centers. In those cases where they are stationed at a VAMC, the RVSRs serve in a liaison role. The RVSR assists the medical center by ensuring the examinations are completed timely and that the examination reports are sufficient for rating purposes.

There can be no doubt that initiatives such as the Benefits Delivery at Discharge program and placement of RVSRs at medical centers add significant value to customer service and the delivery of quality decisions, the current claims inventory and the need for all FTE possible to attack it do not permit the dedication of further

additional staffing to outbased locations at this time. The Task Force recommended that VBA develop specific criteria to determine when staffing levels are adequate to support expansion to additional outbased sites.

*Question 3.* VBA's efforts to go paperless seem to have shifted from a whole Compensation and Pension (C&P) approach to just being used for pension consolidation. What was the basis for the shift and do you support this more limited approach? The Washington Regional Office (WRO) has been a test site for the paperless office. How will these changes impact the WRO?

Answer. The Virtual VA deployment strategy for the processing of disability compensation claims has been postponed as the direct result of the recommendations of the Claims Processing Task Force regarding new technology implementation in regional offices. The new short-term (two-year) focus of the Virtual VA prototype is to support the Pension Maintenance Consolidation initiative. Initially, the program is being deployed to the Philadelphia Maintenance Center. One regional office (currently expected to be the Baltimore Regional Office) will receive scanning capabilities to test the feasibility of scanning records at a local regional office for transfer to and storage at a Pension Maintenance Center.

The timeline for the long-term goals for Virtual VA will be dependent upon the success of inventory reduction, cooperative technology planning with the VA Chief Information Officer, and continued funding.

I am told that the Washington Regional Office was the test site for the original Highway I prototype for this project. However, to minimize impact on their workload and achievement of their goals, VBA's Compensation & Pension Service built a Systems Development Laboratory in the Fall of 1999. While this Systems Development Laboratory presently shares office space at the Washington Regional Office, C&P Service hired and dedicated separate C&P Service resources to work on Virtual VA. Consequently, there will be no impact on the operations of the Washington Regional Office.

*Question 4.* I have serious concerns about the adequacy of training of VBA adjudicators. The Task Force report noted that there were initial suspicions that the new centralized training programs for VSRs and RVSRs had been planned quickly and executed poorly, but after closer examination the task force members were encouraged by the results. Nonetheless, you note that VBA still has no fully integrated training plan. Can you explain why you were encouraged by those findings, and list the ways in which you would improve training of adjudicators.

Answer. Over the past several years with the financial support of the Congress, VBA has acquired some very valuable training resources both in terms of the professional training staff in Orlando and its infrastructure assets for the delivery of training. These assets include VA's satellite network, its Training Academy in Baltimore, and its video conferencing system. Our Task Force was impressed with the computer-based training modules that have been developed for the Rating Veteran Service Representatives (RVSRs) and Veterans Service Representatives (VSRs) and were used last year in the centralized training efforts to support VBA's hiring initiative. The Task Force, however, did identify several significant improvement opportunities. These opportunities included development of certification programs for instructors and journey level positions; targeted training for each grade level in the VSR and RVSR job series; and greater use of the Baltimore Academy and Orlando Instructional Systems Design assets. We also saw a need for organizational changes that will facilitate the integration of the training plan throughout VBA. A VBA task team was formed to develop an implementation plan for the Task Force's recommendations.

*Question 5.* What changes do you anticipate making to the way quality is measured at VBA?

Answer. The VA Claims Processing Task Force recommended redefining claims processing errors. Correcting substantive errors and taking steps to prevent future mistakes requires that serious material defects be identified and measured apart from the procedural defects. VBA has already modified the quality assurance review process (STAR) to implement this recommendation. Beginning with reviews of work completed in FY 2002, the accuracy rate will be captured based on the following review categories: addressing all issues, VCAA-compliant claims development, correct decisions, and correct payment dates. This core accuracy measurement will be labeled "benefit entitlement." It will be recorded on VBA's balanced scorecard and will be the official accuracy rate for compensation and pension claims processing.

*Question 6.* What is your general philosophy regarding the use and effectiveness of decentralized pilot programs and test stations? Please describe what strategies you would implement to coordinate and monitor all of the pilot programs at regional offices.

Answer. If by "decentralized pilot programs" you are referring to independently and locally developed information technology or process change initiatives, I do not support that approach to change management. Although I strongly encourage innovative ideas and suggestions for change, those ideas need to be centrally assessed and controlled. This centralized control is necessary to ensure that VBA has consistent policies and procedures for serving veterans throughout the country. I do believe that after an initiative is approved at the headquarters level, new processes and technology initiatives must be thoroughly tested and piloted at Alpha and Beta sites in the field. In establishing these tests and pilots, VBA needs to clearly identify and measure the criteria that will be used to determine whether the initiatives will achieve the performance goals that they were designed to meet before they are deployed nationally. The Claims Processing Task Force specifically addressed the need for a formal "change management process" within VBA (Recommendation S–14).

*Question 7.* Inadequate, incomplete or untimely C&P examinations have been blamed for many of the delays in the claims adjudication process. They are one of the main reasons for BVA remands. What is the status of the VBA pilot program to contract with non-VA physicians to conduct C&P exams?

Answer. I have been advised that the VA Contract Medical Disability Examination Pilot is currently in its third option year with QTC Medical Services, Inc. The fourth option year, which is the final option year in the contract, will be exercised on May 1, 2002. The Compensation and Pension Service has drafted a statement of work (SOW) for another five-year period (base plus four option years), but has also added that additional option years may be added based on good performance. During our deliberations, the members of the Task Force heard no derogatory comments about the QTC examination deliverables.

*Question 8.* What are your plans for increasing the exchange of information between VBA and its partner agencies, such as the Department of Defense and Social Security Administration, for use in VBA eligibility determinations? Also how specifically can VA and DoD improve their hand off of servicemembers leaving the service with a disability?

Answer. I have learned that VBA has a successful agreement with the Social Security Administration (SSA) which allows for joint on-line access to respective databases. The Pension Maintenance Centers provide a current example of the success of this initiative. Employees at these sites are currently using direct access to SSA income information to improve the timeliness of pension claims processing.

As to data exchanges, I believe that every effort should be made to fully leverage the data and technology capabilities of DOD to enhance delivery of services to veterans

I have been advised that there are significant opportunities to improve the current data and information exchange processes between VBA and DOD and that improvement efforts are under way.

For example, I am aware that VBA has entered into an interagency agreement with the DOD Defense Manpower Data Center to establish an electronic exchange of VBA defined demographic and military history data from the Defense Enrollment and Eligibility Reporting System (DEERS). I have also been told that a joint effort is now underway with the DOD to develop an interface which would allow on-line access to imaged documents contained in service member's personnel files, to include DD 214s. I am also aware that the Acting Under Secretary for Benefits has initiated dialogue with the Assistant Secretary of Defense for Force Management Policy to create a VA/DOD Joint Benefits Council and that expanded and improved information sharing is the first targeted improvement objective.

As Under Secretary for Benefits, I will continue to support these efforts to ensure that veterans receive the services and benefits they have earned in a timely and responsive manner

*Question 9.* What is your understanding of the relationship between the VBA and the Board of Veterans' Appeals? How is the implementation of the Board's development of evidence affecting VBA? How closely do the two organizations interact on common outcomes, such as the implementation of decisions from the U.S. Court of Appeals for Veterans Claims?

Answer. VBA and BVA are currently working very closely to ensure successful implementation of the Task Force recommendation advocating that BVA develop for "additional information" rather than remanding appeals back to regional offices. Regional offices support this initiative because development of evidence by BVA will decrease the amount of time they spend on performing such work. But more important, it can dramatically shorten the length of time to consider an appeal.

Our Task Force was briefed on the cross-organizational process that the Secretary established to analyze and disseminate Court decisions. It involves the Office of

General Counsel (OGC), the Board of Veterans' Appeals (BVA), and the Compensation and Pension (C&P) Service. The Appellate Litigation Group of the OGC distributes the Court's Orders and decisions to the BVA, OGC, and the Judicial Review Staff of the C&P Service on a daily basis. The principals of those activities regularly discuss the decisions and their impact on operations throughout VBA. This group leads the effort to interpret the Court's rulings, disseminate information and monitor compliance with the Court's rulings. In addition, BVA and the C&P Service produce timely written assessments of the Court's case law and disseminate these assessments to all VBA decision makers.

*Question 10.* Some veterans service organizations have suggested that there should be more accountability for VBA decisionmakers. The Task Force you chaired also stresses the need for accountability. The VSOs suggest tracking decisions by adjudicators that are overturned by BVA and hearing officers, or remanded by BVA. Such statistics could be used to determine when additional training is needed or to determine a basis for merit bonuses. What are your views on this method of quality control?

Answer. Decisionmakers should be held accountable for the quality of their work. But in holding decisionmakers accountable, we must ensure that a fair system is in place to accurately judge the quality of the decisions made.

BVA remand and allowance rates are not necessarily good indicators of the quality of decisions made at the regional office level. First, BVA has de novo review authority, allowing them to overturn regional office decisions based on judgment variance. Second, appellants can submit new evidence to BVA after the appeal has been certified to BVA. Finally, changes in the laws or regulations (e.g., enactment of the Veterans Claims Assistance Act) or a Court decision, during the appeal period, can result in BVA overturning a regional office decision or remanding a case back to the regional office.

VBA tracks quality nationally by using a review process called Systematic Technical Accuracy Review (STAR) to evaluate decisions made at each regional office and to determine national training needs. Local quality reviews, based on STAR protocol, are used to evaluate the quality of work performed by individual decisionmakers. The data from these local reviews will be used by regional offices to determine where training needs exist and to evaluate the performance of decisionmakers.

*Question 11.* One of the Task Force's chief recommendations is that successful offices should receive priority for increases in FTE and funding, while offices that experience chronic problems should be, in essence, denied further resources. This philosophy rewards achievement, but also reinforces failure by making no provision for rehabilitating offices that fail to meet expectations. Do you believe that this will result in an improved experience for veterans in the long run? Are there steps that could be taken to aid under-performing offices in order to maintain VBA's regional presence consistently?

Answer. The Claims Processing Task Force recommended that VBA allocate new staffing resources to high-performing and high-quality regional offices. This recommendation was made in the context of the apparent random hiring that occurred during FY 2000 and 2001. The Task Force report specifically identified the need to have an integrated and well-understood hiring strategy based on workload, efficiency, and demonstrated need. The focus of the recommendation is to have a cohesive strategy for getting resources to the stations that can most effectively address our national workload challenges.

The FY 2002 model also allocated resources to support the accomplishment of the Secretary's priorities, which resulted in staffing allocations for VBA's Tiger Team, the Resource Centers, and the Pension Maintenance Centers. All of these initiatives provide additional support to offices experiencing workload difficulties. These types of initiatives will continue to provide support for veterans living in regional office jurisdictions that have historically performed poorly.

I have been advised that there are several other initiatives under way aimed at providing support to some of the lower-performing stations. These include two-week "Help Teams" and support from the Satellite Rating Activity at the Huntington Regional Office, which works a total of 350 cases per month for other offices.

The Claims Processing Task Force also recommended that VBA hold senior executives accountable for performance. New performance standards for directors emphasize quantifiable performance measures. As part of this emphasis on accountability, VBA will focus on performance management and look at the underlying causes of poor performance in some regional offices. This will be accomplished by reducing the span of control through the implementation of four Area offices and by increasing oversight through site surveys and on-site reviews. The focus will be on identifying and correcting poor performance so veterans receive the same level of service at all VBA regional offices.

*Question 12.* The Task Force that you chaired recommended in its report that VA should reorganize and clarify the Compensation and Pension program regulations and manuals. What is your strategy to implement these changes?

Answer. VBA is supporting a Department-level initiative to reorganize and clarify the basic eligibility regulations contained in 38 CFR, Part 3. A group of fifteen employees from the C&P Service, the Office of the General Counsel, and the Board of Veterans' Appeals will be included in the initiative. Besides reorganizing and rewriting the Part 3 regulations for clarity, the project will also identify substantive rules contained in manuals or other directives that should be included in the regulations.

When the project is completed in February 2004, the Part 3 regulations will be completely reorganized and rewritten for clarity and consistency, as well as congruence with the authorizing statutes. The regulations will also be strengthened to better reflect the pro-veteran, non-adversarial intent of the laws that has been the hallmark of all veterans' laws since their inception.

I will be attentive to the manner in which directives are issued by VBA. I will work to assure clarity and consistency and to reduce the volume of releases that contribute to confusion by our field employees.

*Question 13.* The Task Force also recommended several measures that they believed would speed up the appeals process. For example, it advocated development of remands in BVA rather than at the RO level. How do you plan to accomplish this without adding to the appeals backlog?

Answer. The implementation of the Task Force recommendation to require BVA to develop for evidence rather than remanding appeals back to Regional Offices will assist in reducing the appeals backlog. The implementation of this initiative will also result in the expeditious processing of appeals.

To negate any adverse workload impact at BVA, a fully staffed development team was hired to perform this function. With full support from both BVA and VBA, this development team has received comprehensive training. The daily communication and the sharing of ideas between representatives of BVA and VBA are largely responsible for the positive steps made in achieving the goals established by this Task Force recommendation.

*Question 14.* The Task Force's instructions from the Secretary restricted recommendations to matters that would not require a change in law. What changes in law would be needed to address VBA's problems?

Answer. Because the focus of the Task Force was to work within the framework of the existing law, we did not devote any time to considering proposed changes to existing Compensation and Pension law. As a general principle, I believe regular review of veterans programs by Congress is valuable in determining if they are functioning as intended and whether or not statutory changes are warranted. I am aware that a formal program evaluation of the Dependency and Indemnity Compensation Program was completed last year and that an evaluation of the Pension Program is currently underway. I am also advised that a thorough program evaluation of the Disability Compensation program is scheduled for 2004. In this connection, I understand in 1999 and 2000 that VBA convened stakeholder meetings which included representatives from veteran service organizations, congressional staff, OMB and the Department to discuss disability compensation program outcomes goals and measures. These discussions and evaluations should provide valuable information for Congress to consider.

*Question 15.* I know that in preparation for the Task Force's report, you consulted prior analyses of the claims processing system. What are your views of the report of the Congressionally-chartered Adjudication Commission, chaired by Mr. S. W. "Mel" Melidosian? And have you spoken with him or others responsible for that effort?

Answer. The Task Force not only reviewed the previous reports on claims processing prepared by the National Academy of Public Administration (NAPA) and the Veterans Claims Adjudication Commission (VCAC), we also received briefings from Milton Socolar, the Panel Chair for the NAPA study, and Mel Melidosian, the Chairman of the VCAC. We also had the opportunity to hear from Darryl Kehrer on the House Staff, who was the Executive Director for the VCAC. Our Task Force was impressed with the reports and findings of these earlier study groups and learned a great deal from their experience. Mr. Melidosian also attended several of the Task Force's open hearings and offered comments during those hearings. Although I have not personally met with him, I intend to request a meeting with him, if confirmed.

There were four major concerns regarding the administration of VA benefits addressed by the Melidosian Commission: the lack of finality in the claims process, claims processing problems, the system for administrative appeals processing, and inadequate strategic management. Some of the issues the Commission covered fell outside the scope of our Task Force as they involved legislative changes (e.g., the

lack of finality in the claims process and lump sum payments to veterans with minimal disabilities). Other issues, such as expanding the role of the Hearing Officers and acquiring actuarial expertise, have already been adopted by VA. It is my understanding that much of the data analysis conducted by the Commission has been captured and expanded in VBA's current Annual Report, which was a direct outgrowth of the Commission Report. There were other concerns and recommendations that the Claims Processing Task Force embraced and addressed in our own report, such as the need for greater partnerships with veterans and their representatives in the Veteran Service Officer Community at the county, state and national levels. We also endorsed the call for better strategic management and made recommendations to strengthen VBA's data analysis capability.

*Question 16.* VA has finally moved to add several cancers to the list of diseases presumptively connected to exposure to ionizing radiation. However, veterans must still contend with the dose-reconstruction process to establish exposure levels, a process that many veterans and scientists believe may lack validity.

a) An Institute of Medicine committee is currently reviewing the accuracy of the dose-reconstruction method in use, but that doesn't address the question of whether veterans should have to prove individual exposure. In your view, is the dose-reconstruction method a necessary tool for determining whether veterans should be eligible to receive compensation for radiation-related diseases?

b) In 1991, Congress enacted legislation charging VA to contract with the National Academy of Sciences to periodically review the scientific literature to determine associations between health conditions and exposure to herbicides like Agent Orange. The NAS reports are intended to advise the Secretary in determining what conditions warrant presumptive service connection. In 1998 Congress mirrored this bill, providing a similar process for Gulf War veterans. However, veterans exposed to ionizing radiation have experienced a more piecemeal approach to compensation. In your view, is there value in crafting authority for atomic veterans similar to Agent Orange and Gulf War legislation?

Answer. These are important issues that I would like to study further before taking a position. When I have reached a conclusion, I would be pleased to share my position with you.

*Question 17.* Recent scientific research suggests that former World War II and Korean prisoners of war may be at an increased risk of dying of chronic heart disease or cirrhosis when compared to fellow veterans. If confirmed, how would you follow up on these findings, and would you consider recommending service connection for chronic heart disease and liver disease for former POW's?

Answer. I have been advised that the Veterans Health Administration has convened an Expert Panel on POW Presumptions. It consists of medical experts who are reviewing the medical literature in order to address the possible relationship of a number of conditions, including cardiovascular and liver diseases, to the prisoner of war experience. The Panel is expected to deliver its report this spring. After VBA and VHA review this report, VBA will consider the issue of whether or not heart and liver diseases, or specific types of these diseases, should be presumptive conditions for former prisoners of war and appropriate recommendation will be made to the Secretary.

I am keenly aware of the sacrifices made by POWs and their families. Clearly the unique hardships associated with their captivity warrant special consideration and I will carefully evaluate any findings.

*Question 18.* VA and the Department of Labor support a shift of veterans' employment and training services to VA. Do you support the shift? If this were to occur, how would you ensure that veterans have access to outside job placement resources?

Answer. Yes, I support the proposed transfer of the Veterans Employment and Training Service from the Department of Labor to VA. I realize that there are many details to be determined for full integration of VA's and DOL's missions to provide job placement services to veterans. I believe that utilization of competitive, performance-based grants that leverage existing and emerging technologies in the market place is a key strategy to ensuring we meet the employment needs of veterans, particularly disabled veterans. Also, strong outcome and performance measures, which I am told have not historically been in place, need to be established so that VA can ensure veterans receive the highest level of services.

*Question 19.* VA recently decided to focus more on employment in the Vocational Rehabilitation & Employment Program. How do you assess VBA's current efforts concerning employment of disabled veterans? How do you plan to ensure that disabled veterans are affirmatively hired and promoted as required under Title 38? How would the addition of VETS to VBA's services affect the needed emphasis on the special job placement needs of disabled veterans?

Answer. I have been advised that over the last few years VR&E has engaged in a number of strategies that embraced its renewed focus on employment. While these strategies have yielded substantial improvement in VR&E's rehabilitation rate in the past three years, improvements still need to be made. I will support efforts to further reduce the drop-out rate and ensure sustained employment and career advancement for disabled veterans. I am told that VBA is pursuing a strategy that uses a new Employment Specialist position to enhance communications with employers. This concept offers promise to improve the rehabilitation rate and I will explore it further, if confirmed.

If the decision is made to add VETS to VBA, I think VA will have the opportunity to consider new ways to effectively meet the employment needs of veterans. This should be done in a manner that integrates and complements the other parts of VA's mission, especially those that address the needs of disabled veterans. I look forward to working with the Secretary to ensure the transition is accomplished in a way that improves employment services to disabled veterans and increases job opportunities for all veterans.

*Question 20.* GAO has reported that serious computer security problems persist within the VA health care system, endangering the privacy of veterans' medical records. Many of the problems came down to access—too many personnel could access private information, due to problems with both physical and network security. Given that both VA health care and benefits providers must soon comply with new, more stringent federal health privacy regulations, how will you ensure that VBA shares in a truly integrated department wide information security management strategy that meets the new standards?

Answer. I have been informed that, in order to enhance information security in general, VBA is working very closely with the VA Office of Cyber Security (OCS), which was established in the past year and reports to the VA Chief Information Officer. I will make sure that VBA continues to coordinate all security matters with the OCS. I will also require that VBA's Security Infrastructure Protection Office and Chief Information Officer work daily with their counterparts to ensure that VBA is being responsive to all security matters/concerns and complies with all Congressional mandates and federal guidelines.

Additionally, a joint VBA and VHA work group has been established and is charged with developing recommendations to ensure only appropriate access to veterans' health records. I will ensure that VBA continues to participate in this effort, including the implementation of measures approved by the Secretary.

*Question 21.* How will you improve VBA's efforts to meet VA's "One-VA" enterprise solution vision? As legacy systems migrate towards new technology solutions, staff needs to be educated and flexible. How will you support these requirements?

Answer. VBA has participated extensively in the VA Enterprise Architecture, which builds on the interdependencies and interrelationships among the administrations. If confirmed, I will require VBA to continue supporting the development of this initiative. Part of this will include a migration strategy toward technology solutions to support the claims process.

This migration strategy will include the identification of the information technology (IT) work force of the future. The Assistant Secretary for Information and Technology has begun the development of an IT workforce initiative, designed to match the work force of the future with the envisioned or "end state" VA technology. VBA will continue to contribute to and benefit from this effort that is already underway.

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## RESPONSE TO WRITTEN POST-HEARING QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO DANIEL L. COOPER

*Question 1.* If confirmed, do you intend to continue any of VBA's Business Process Reengineering initiatives? If not, what measure would you implement?

Answer. There are several initiatives that VBA implemented as part of its broad business process reengineering plan that I believe have had a positive impact on the service provided to veterans and should continue. One of the many documents that the Task Force reviewed was the semi annual report on the status of VBA's BPR initiatives. Many of the initiatives covered in this report—which include the Benefits Delivery at Discharge Program, the establishment of the Decision Review Officer position, the TRIP initiative (Training, Responsibility, Involvement, and Preparation of Claims), the Contract Medical Examination Pilot, the technology initiatives implemented to improve phone service, and the certification program for Veterans Service Representatives—were endorsed in one form or another by the Claims Processing Task Force.

The Task Force did have a different view of the extent to which case management should be applied in the claims process. The Task Force recognized the importance of providing certain claimants with "status updates" regarding their claims. The Task Force did not believe that all claims required case management, but that the process should be applied in cases that involved claims submitted by Ex-POW's, terminally ill veterans, homeless or financially distressed claimants, or those filed by veterans who are claiming a disability as a result of sexual trauma.

*Question 2.* How will the shift from an "assembly-line" approach to claims processing to a "working group" approach affect the development of Training Performance Support System (TPSS) modules?

Answer. No changes will be required in the training modules that have been developed for the Rating Veterans Service Representatives since they will be part of one of the self-contained specialized work teams. There will have to be some changes in the recently developed Veterans Service Representative training modules in terms of the sequencing and grouping of some of the skill sets required for the various teams. I have been advised by the Compensation and Pension Training Staff that this should not be a difficult task. It is likely that the "working group" approach will allow for a more focused design of the TPSS modules and the job/training aids for VSRs.

*Question 3.* Do you have any plans for reorganizing VBA, either in VA Central Office or in the field? Please include your views on the potential consolidation or merger of processing functions.

Answer. The VA Claims Processing Task Force recommended to the Secretary that VBA eliminate the Service Delivery Network organizational structure and establish an appropriate number of Area Offices in the field (at least four) with line authority over the Regional Offices.

The Secretary approved the proposal to have four Area Directors, with 12 to 16 Regional Offices in each Area. The Area Directors would report to an Associate Deputy Under Secretary for Field Operations. Functional requirements, tables of organizations, and position descriptions are now being finalized. Service Delivery Networks (SDNs) have been eliminated as entities.

VBA has already acted on the Task Force's recommendation to consolidate the pension maintenance functions into three centers that are located in the Regional Offices in Milwaukee, Philadelphia, and St. Paul.

VBA is considering a reorganization plan for Central Office based on the recommendations of the Task Force.

*Question 4.* The Task Force report recommends that VA perform a study to determine the best location for specialized operations. Some of the factors to be considered include the ability to recruit a skilled workforce, proximity to vet population centers, availability of space, as well as quality and timeliness of work consistently produced. If you are confirmed, will such a study be performed? Also except for an analysis of quality and timeliness of work, wasn't this the approach the Task Force criticized VBA for using when it hired extra-budgeted staff in the last two years?

Answer. If confirmed, I would not plan to initiate any new studies to establish specialized operations until VBA's workload situation is stabilized. One of the findings of the Task Force was that change, even a positive one, comes with a cost. The cost is incurred by the temporary loss in productivity as employees are pulled off line to assist with training, developing new procedures, and implementing the new operational units. As VBA begins to reduce the backlogs, we will look for more opportunities to establish specialized operations similar to the Pension Maintenance Centers that were recommended by the Claims Processing Task Force. Several of these opportunities are listed in a chart that accompanies the recommendation on developing specialized Regional Offices (S–9).

The staffing allocation methodology that was apparently used previously considered only the ability to recruit plus the availability of space and proximity to veteran population centers. The allocation methodology recommended by the Task Force focuses on performance. Quality and timeliness are two of the critical performance measures that VBA must consider in making staffing decisions. Another critical performance measure is productivity, which was discussed in the Task Force's recommendation (S–10) concerning staffing resource allocation.

*Question 5.* The Task Force noted that there are several "super-sized" regional offices and found that the method of resourcing and organizing should not be different whether it is a very small or very large office. It seems to me that some of the super-sized ROs or those located in big cities are often the poor performers. Don't you agree that these offices face distinct challenges, that places such as the Huntington Regional Office, which has a very stable workforce, don't face? Also, how do you plan to address the distinct needs of the very small offices that only have one

person performing a function, that undergo hardship if that person resigns or retires?

Answer. The performance data that I have reviewed does not indicate that size of an office necessarily determines whether or not that office is successful. Several of VBA's larger offices are, in fact, performing well. For example, the Houston and Winston-Salem VAROs have exceeded their production goals. Houston has produced 114% of its target and Winston Salem has produced 109% of its target. Both offices are also processing cases in less time than the national average. The Cleveland Office was selected as the site of the Tiger Team because it has traditionally been a high performing office. At the same time, there are several smaller stations that have sub-par performance levels that need to be improved.

While the cost of living and other economic factors can have an impact on the ability of a station in a large city to recruit a highly qualified work force, I believe the critical factor in the success of any office, large or small, often comes down to the leadership and management skills of the Director and his or her management team.

The key to dealing with one-of-a-kind positions, whether they exist in a large or small office, is to ensure that you have an effective cross-training plan in place so an alternate can step in temporarily to fill a vacancy until a permanent replacement can be found. Regional offices also need to have a succession plan in place so that losses are anticipated and replacements are hired and trained before the vacancies occur. One of the critical functions that the headquarters elements must provide is training programs that regional offices can use to develop the skills of every position in the organization. The Claims Processing Task Force recommended that VBA establish a training plan for each employee consistent with the requirements of their job series. I intend to ensure that this recommendation is implemented.

*Question 6a.* To follow up on your response to my prehearing question #9, regarding the Board of Veterans' Appeals greater involvement in the claims process:

What specific changes in VBA have resulted from the Board's development of evidence, such as the process for dealing with remanded claims and the increase in production associated with remanded work?

Answer. Since February 25, 2002, BVA has begun to develop over 600 appeals instead of remanding them to field offices. In addition, VBA requires field offices to certify to BVA a defined number of appeals each month.

*Question 6b.* Since the Board is now developing evidence rather than remanding cases for further development, how will you ensure a feedback loop to regional offices to notify them of any errors in the underlying decision?

Answer. BVA and VBA have a joint tracking system that identifies cases that the Board retains for development and the reasons these cases required additional development. The number of such cases is tracked for each office, and a monthly report provides for feedback and monitoring by C&P Service and the Office of Field Operations.

*Question 6c.* What action will you take so as to maintain a sense of ownership by regional office adjudicators?

Answer. Egregious cases will be returned to Regional Offices. Instead of a remand rate alone, offices will be provided information on their combined remand plus BVA development rate.

*Question 6d.* What responsibilities, if any, will the regional offices have in either notifying the veteran or responding to inquiries concerning any development being conducted by the Board? What system will be in place to coordinate on these responsibilities with the Board?

Answer. The Veterans Appeals Control and Locator System (VACOLS) is shared by both BVA and the Regional Offices. The Board will notify the veteran of actions they are taking, but Regional Office personnel will have access to all pertinent information regarding the appeal and will therefore be able to answer questions.

*Question 6e.* It is my understanding, that during the past few months regional offices have not worked on appeals. What is the current policy regarding VBA employees working on appeals? What steps would you take to ensure that efforts to maintain a balance in working on claims at all stages?

Answer. On February 20, 2002, VBA issued a letter to all Regional Offices that provided each station with specific production targets for appeals. VBA has provided overtime funds that may only be used to work appeals during designated periods. The Directors' performance plan also includes goals for reducing the number of pending appeals and for improving the processing time for remands.

I believe the actions that VBA has recently taken will ensure that an appropriate balance is maintained between working claims and processing appeals. VBA and ultimately veterans will also benefit from recently implemented recommendations of the Task Force related to appeals processing. The Board of Veterans' Appeals can

now develop for additional evidence, when necessary, rather than remanding cases to the Regional Offices. This initiative will free up resources in the field offices to work appeals and ratings and will result in more timely decisions for veterans.

*Question 6f.* The Task Force recommended that VBA stop new IT initiatives until there is a formal mechanism in place to evaluate and oversee technology projects. While I agree that a more organized and strategic approach is needed, I believe that VBA could improve its processes by taking advantage of innovative technology as it becomes available. Will you create an environment that is open to technological advancement? Will your administration actively seek technology demonstrations and recommendations from private sector and government partners?

Answer. It is my belief that VBA must be open to advances in both technology and business processes. To accomplish this, VBA will continue to work closely with the Department in the continued development and implementation of the VA Enterprise Architecture initiative. The main purpose of this initiative is to align the business and technology processes. Within this initiative, both VBA and VA will ensure that information technology and business processes are linked together and that they are working together as effectively as possible. An important part of this process will be to ensure that the best technology and business processes from both the private and government sectors are identified and successfully applied wherever appropriate within VBA.

*Question 7.* As you explained in your answer to prehearing question #3, the Virtual VA timeline has been put on hold as a result of the Task Force recommendations. You stated in your answers that the timeline for the long-term Virtual VA goals will be dependent on inventory reduction, funding and cooperative planning with the VA CIO. Please be more specific as to a timeline. Also, will you support the paperless office and other technology initiatives to create more efficient C&P processing, once IT decisions are centralized?

Answer. The immediate plan is for Virtual VA to support our Pension Maintenance Consolidation effort. Plans include deployment to the Philadelphia Pension Center during FY02 and to the Milwaukee and St. Paul Centers during FY03. As you state, reduction of the claims backlog, including appeals, is the top priority. Timelines for deployment beyond the pension sites will be dependent on VBA's success in reducing the backlog. Future deployment dates have not yet been determined and require further development.

I strongly support the use of technology to assist in creating efficiencies in C&P claims processing with the ultimate goal of providing high quality service to veterans. Recently developed tools and applications are furnishing valuable information about our pending workload. This information is used to help manage claims through the various stages, identify potential areas of weakness or processing delays, target cases for expedited processing, and provide on-line claims status to assist in answering telephone inquiries. Information Technology applications under development will focus on facilitating the work of the decision-makers and provide important information for the organization. Technology is vital to support our management of today's challenges and will increase in importance. However, technology will not replace real people helping veterans—it will merely help these dedicated people do it better.

*Question 8.* The Task Force Report questioned the viability of VETSNET based on old technology and a concern over whether it is the best long-term solution for VBA's payment system. However, in January, VBA determined that VETSNET is a necessary stepping stone to migrating to new technologies. Do you agree? What outside sources, if any, were consulted in making this determination? How long will it take for your administration to implement VETSNET to a point where it can make an impact on the claims process?

Answer. I agree that VETSNET is an important stepping stone for VBA in the migration from the legacy Benefits Delivery Network to new technology. In making this determination, VBA considered the outcome of a recent independent audit by Abacus Technology Corporation, as well as the assessment of the VA Assistant Secretary for Information and Technology and the report of VBA's IT Task Team. As far as gauging the time when VETSNET can make a favorable impact on the claims process, we believe that this is already occurring in some locations. For example, some locations using Rating Board Automation (RBA) 2000 (one of the VETSNET applications) have experienced an increase in production. However, because of perceptions that the introduction of new applications may adversely affect workload, we have decided to develop a systematic field strategy that will include conducting an "impact analysis" prior to the roll out of each application. We will use this strategy to develop an acceptable implementation time frame designed to maintain the highest overall production while still allowing the introduction of modern technology, including the completion of VETSNET.

*Question 9.* In response to pre-hearing question #8, you discussed the opportunities to improve the exchange of information between VA and DOD. Currently, the barriers to making a seamless transition from active duty servicemember to veteran seeking VA benefits range from incompatible technology to limited knowledge of eligibility to process differences between VA and DOD. What management strategies do you plan to implement to remove these obstacles?

Answer. The recently established VA/DOD Joint Benefits Council, discussed in my response to the pre-hearing question noted above, holds great promise as a forum for addressing the many areas of common interest and overlap that will ultimately enhance our ability to more effectively partner with DOD to improve service delivery. I intend to fully support the council by appointing knowledgeable VBA representation and as necessary, becoming personally involved in matters impacting our ability to overcome inter-operational obstacles.

At this point, preliminary Benefits Council discussions have identified three "top tier" collaboration objectives: data and information sharing; improved records access and refinement; and formalization of transition procedures and protocols. Specific to data and information sharing, the Council has discussed the establishment of an information management coordinating body to focus on the execution of existing interagency agreements and development of policy and procedures to ensure a business-driven exchange of critical service member and veteran data to support both tactical service delivery and strategic planning.

An essential element of timely benefits decisions is timely access to documentary evidence contained in military records stored at DOD-operated facilities. As discussed with the Assistant Secretary for Force Management Policy, it is my understanding that VA has agreed to consider various options including expanded co-location of VA staff at DOD records centers, as well as enhanced utilization of emerging technologies to improve records retrieval and thus benefit determination decisions.

Cooperative initiatives such as Benefits Delivery at Discharge (BDD) and the establishment of a joint VA/DOD separation examination process have proven very successful. Building on that success, I will support the further development of complementary procedures and protocols for separation, retirement and disability examinations and evaluations.

*Question 10.* There have been several high profile incidents in the last few years of employee fraud at the VA Regional Offices. Please describe your views on how employee theft should be addressed within VBA. What steps would you take to monitor regional offices?

Answer. VBA has taken a number of actions to minimize the possibility of employee fraud. I would continue to implement the procedural and systematic changes necessary to improve VBA's internal controls. Most important will be the increased accountability of managers to ensure that proper procedures are followed. The VA Claims Processing Task Force found that "accountability—is the most serious deficiency in the VBA organization."

Based on the recommendations of the Task Force, VBA is enforcing more accountability for managers, particularly in the areas of internal controls. For example, Directors' performance standards were revised for FY 2002. A number of specific performance expectations were added or strengthened. The performance element of Program Integrity, which covers areas such as Office of Inspector General (OIG) findings, is a critical element.

As of August 2001, Directors or their Assistant Directors are required to personally review all Compensation and Pension payments over $25,000. They receive notification by email on a bi-weekly basis and must complete and return the review within 15 days. Any deficiencies found are reported to VBA's Office of Program Integrity.

The OIG recently visited all regional offices to conduct a review of large one-time payments for the period January 1996 through August 2001. The areas of review included the security of employee folders and employee access to sensitive files. OIG examined several IT security areas, identifying deficiencies that required corrective action. Regional Offices are currently making those corrections. Additionally, VBA requires special analyses of these deficiencies to include why they were found and details of the corrective actions being taken to prevent future discrepancies.

To identify "suspect" claims below the $25,000 threshold, VBA recently completed a data mining Pilot utilizing proven commercial technology and applying statistical analysis techniques to the C&P benefits payment process. Currently, VBA is evaluating available Data Mining technology.

Finally, VBA is enlarging and expanding its Office of Program Integrity. This office will be responsible for working with field stations, VBA program offices, and other VA organizations, such as the OIG. I support the recent VBA efforts to strengthen program integrity. I will work to expand and improve the VBA internal

controls systems, to resource those efforts fully, and to steadily diminish risk of fraud and mispayment in our delivery systems.

*Question 11.* One of the quickly implemented recommendations of the Task Force was to make a special effort to address the oldest claims and claims of older veterans. What is the status of this project and what changes, if any, do you intend to make?

Answer. A Tiger Team has been established in Cleveland to expedite resolution of VBA claims pending over one year, especially for veterans age 70 and over. The Tiger Team became operational in November 2001. Concurrent with this, the Tiger Team Director operationally controls the resources of the nine Resource Centers (RCs) located throughout VBA. The RCs' claims processing activities under the Tiger Team initiative began October 1, 2001.

The Tiger Team is responsible for developing needed evidence, preparing rating decisions, and processing award actions. The RCs prepare rating decisions and process award actions.

Under the Tiger Team initiative, special arrangements have been formalized with the National Personnel Records Center to retrieve military records. These arrangements have caused NPRC's productive output to double and information to the Tiger Team is routinely provided within two days. Also, special arrangements have been made with the United States Armed Services Center for the Research of Unit Records (CURR) and the Defense Threat Reduction Agency to secure needed evidence in an expeditious manner for Tiger Team claims.

The Tiger Team's goal is to complete no less than 1,328 claims per month. The RCs are to complete no less than a combined 2,158 per month through end of March. The RCs' goal increases by 50% for the month of April.

To date, the Tiger Team and RCs have met all monthly goals since implementation. Through the end of February, the Tiger Team has completed 5,710 claims and the RCs have completed approximately 11,886 claims. The combined productive output of the total initiative through February is nearly 18,000 claims.

*Question 12a.* VBA has recently assigned production quotas, which will require some regional offices to almost double their production for the month of August 2002 as compared with October 2001. Specifically, how will these goals be reached? Will you continue or institute a practice of diverting staff from training, supervision, and management to process claims? If so, what will be the impact of that practice for the long-run success of regional offices?

Answer. VBA has begun to reap the benefits of its long term investment in hiring and training a cadre of over 1000 new claims processing personnel (Veterans Service Representatives and Rating Veterans Service Representatives) over the past two years. As these employees become more experienced, VBA's production output has increased significantly. In January 2002, VBA completed more than 62,000 rating cases, the most productive month in nearly four years. This production was continued in February, when almost 63,000 rating claims were decided despite the fact that February had only 19 workdays. This has been accomplished without diverting staff from training, supervision and management to process claims. It is my understanding that VBA did not consider Decision Review Officers, supervisors or managers in establishing rating output targets for regional offices. Output targets are based on the numbers of RVSRs in each regional office and the RVSRs' experience levels.

I expect VBA's productive capacity to continue to increase as we implement the Task Force recommendations. Included among those recommendations already having a significant impact are: establishment of the Pension Maintenance Centers; formation of the Tiger Team in Cleveland; and creation of the Board of Veterans' Appeals Development Unit. As a result of these recommendations, regional offices are able to focus additional resources on the claims backlogs. Implementation of specialized processing teams in the Veterans Service Centers, although still in the early stages of testing at four regional offices, is also showing very promising results. Many more of the Task Force recommendations will be implemented in the coming months.

*Question 12b.* Is the classification of work measurement by end product codes using "one to seven issues" and "seven and above issues" a meaningful measurement tool in light of the trend toward claims with dozens of issues?

Answer. The work measurement system as I currently understand it provides a meaningful tool for assessing resource utilization. It discriminates based on two main factors: (1) the type of issue claimed, i.e., compensation or pension; and (2) for original compensation or pension claims, if there are more than seven issues claimed. As such, the work measurement system is an effective tool. I do believe it could be improved, however. I foresee enhancements that would track issues rather than claims. This will provide finer distinctions and enhanced predictive capacity.

Work on this concept must be deferred, though, while VBA stabilizes processing and the pending inventory.

*Question 13.* For years, this committee has wrestled with the potential long-term consequences of battlefield exposures, ranging from Agent Orange in Vietnam to the environmental hazards of the Gulf War that we still don't completely understand. With each new conflict and new finding, VA, veterans, and Congress seem to react as though this is a new issue. It seems to me that VA—together with DOD—could work together to develop a better strategy for anticipating post-exposure compensation and health issued. Do you agree and, if so, how would you go about this?

Answer. I agree that VA should attempt to anticipate the compensation and health care needs of today's service members, who will be tomorrow's veterans. In this regard, the Veterans Benefits Administration included a chapter entitled, "The Future—Forecasting Program Liabilities," in its last VBA Annual Benefits Report. If confirmed as Under Secretary, I would ensure that such efforts continue, and I would expand them as necessary.

I also agree that coordination between VA and the Department of Defense (DOD) can help us achieve this goal. Earlier this year, VA and DOD formed joint Executive and Health Benefits Councils. This is part of a long-term commitment by the two departments to build a more collaborative relationship. The two panels will work together to improve coordination between the departments in such areas as health care services, benefits delivery, information sharing and capital asset coordination.

*Question 14.* In your responses to the prehearing question #1, you listed eliminating claims backlog in education and implementing expanded education benefits as one of your top priorities for improving VBA. However, your answer does not discuss your plans for changing the status quo in education claims administration. Please clarify your plans.

Answer. Timeliness of education claims processing has been improving during the first five months of fiscal year 2002. When compared to the same period last year, the pending claims inventory in education is lower.

VBA has taken the following steps to change the status quo in education claims administration:

- 100 new claims examiners were trained and are gaining experience, resulting in improved timeliness of claims processing.
- Seasonal employees and Education Liaison Representatives answer calls to help reduce the number of callers who can't complete their calls. Seasonal employees are most beneficial during peak workload periods (August-October and January-February).
- Web Automated Verification of Enrollment (WAVE) became available to claimants in late FY 2001. WAVE allows MGIB beneficiaries to verify their continued enrollment each month over the Internet instead of mailing the verification form. This improves communication with claimants and speeds release of monthly payments. Although installed too late in the fiscal year to have a significant effect, it will reduce paperwork in the regional processing offices and speed the benefit payment process.
- Electronic Funds Transfer (direct deposit) was expanded to the MGIB–SIR (chapter 1606) program, making funds available to these claimants 3 to 5 days earlier than if a check were mailed.
- Continued improvements in Enrollment Certification Automated Processing (ECAP), allowing more cases to be processed without human intervention. ECAP is a proof-of-concept prototype that uses 4(expert" or rules-based systems to process claims in a totally automated environment. At this point, only 3–4 percent of all incoming work is completely processed in this way. A more sophisticated rules-based application will allow many more claims to be completed without human intervention.
- VBA is developing a system to enhance customer service delivery by integrating people, processes, and technology to manage veteran interactions through all means of communication. This will result in improved access to information over the Internet as well as improved telephone service.

*Question 15.* The Loan Guaranty Service Foreclosure Avoidance Through Servicing (FATS) ratio demonstrates what foreclosures VA has prevented for veterans who work with VA and their lenders often to restructure the terms of the loan to accommodate veterans' current financial situation. However, the FATS ratio is a lagging indicator. As a matter of fact, your Task Force's report alluded to an almost one-year lag in the FATS ratio. Would it be possible to formulate a leading indicator that would enable VA to anticipate changes in the number of foreclosures it will face in the near future to adapt more quickly and improve service to veterans?

Answer. The FATS ratio is a performance measure designed to assess the effectiveness of VA efforts in assisting veterans in avoiding foreclosure. It is maintained

on a cumulative fiscal year basis, measuring total performance over the course of the year. It is not intended to be used as a predictor of changes in the number of foreclosures. Since some of the alternatives to foreclosure included in the FATS ratio may take a while for successful completion, such as extended repayment plans, it may sometimes measure the success of efforts initiated many months earlier. However, we believe it is more appropriate to measure successful VA interventions than simply all cases in which VA may have arranged extended repayment plans that veterans were unable to maintain.

In fact, our Claims Processing Task Force limited its report to the Compensation and Pension Program. It did not discuss Loan Guaranty or the other three programs.

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RESPONSE TO WRITTEN POST-HEARING QUESTIONS SUBMITTED BY HON. BOB GRAHAM TO DANIEL L. COOPER

*Question 1.* The St. Petersburg VA Regional Office in February has the highest number benefit claims of pending claims—over 2,000 more claims pending than any other regional office. Although all of VBA's (Veterans Benefits Administration) regional offices have experienced problems processing benefits claims, but these problems are the most prevalent in Florida's single VBA office. Last month, on average, it took the St. Petersburg Regional Office over 228 days to complete a benefit claim. This is unacceptable! How do you plan to reduce this backlog? Does Florida need another Regional Office?

Answer. Reducing the backlog of claims will be my top priority, if I am confirmed. The primary reason for the establishment of the Claims Processing Task Force was to develop specific recommendations that would meet this objective. My plan for reducing the backlog is well documented in the Task Force Report, which included 34 recommendations and 66 actionable tasks. Several of those recommendations have already been implemented and I intend to ensure the remainder are also fully implemented.

I was pleased to note that nationally the pending rating workload dropped by approximately 4,200 cases this past week. St. Petersburg's pending rating workload dropped by 664 cases. As VBA's newer employees become more experienced and, consequently, more productive, VBA expects the pending backlog to continue to decline. The Secretary has given VBA a goal to reduce the pending inventory to 315,000 claims by the end of this year. I intend to aggressively pursue that goal.

The national average for the number of days it took to complete the claims that were processed in February was 230.6 days. The average number of days for St. Petersburg was slightly better at 230 days. I agree that this represents an unacceptable time frame for a veteran to wait for a decision. As VBA reduces its backlog of cases, including the older cases that have been in the pipeline, the average days to complete a case will improve.

In terms of the national inventory of pending claims, St. Petersburg actually has a lower pending balance than could be expected based on its share of claims receipts. The St. Petersburg office normally receives 7% of the national workload. However, the rating claims inventory for St. Petersburg is currently about 24,000 claims, or 5.8% of the nationwide inventory.

I understand that there have been discussions about the need for a second regional office in St. Petersburg, and I would be pleased to continue those discussions with you and your staff, if I am confirmed. I would note that establishing a new office does not represent a short term solution to the current backlog situation. It would take several years to hire and train an experienced staff before a new office would have an appreciable effect on VBA's ability to meet the needs of veterans in Florida.

*Question 2.* You have indicated that you are committed to "feeding the success and starving the failure" of Regional Offices (RO) of the VBA by transferring cases out of low performing offices to higher performing offices. How do you propose to prevent cases from failing through the cracks during transfer? Further, what do you suggest to remedy the failing offices themselves, besides lower their case work?

Answer. It is my understanding that VBA has been transferring cases ("brokering") among offices for several years to take advantage of available production capacity at one office or another to process work or correspondingly offset the lack of capacity at an office. Automated systems are in place within the Benefits Delivery Network to maintain control over the case as it moves from one location to another within the office itself or to another VA facility. To the best of my knowledge, these systems, if used appropriately, prevent cases from "failing through the cracks."

As a result of the Task Force's recommendations on accountability, VBA has established specific performance requirements for every Director that are focused on his or her station's performance.

If a station fails to meet its service delivery goals, the Director is required to provide mitigating reasons why the goal was not met and identify actions that are being taken to improve performance. "Wellness" plans have already been requested of some station Directors who have, thus far, failed to achieve the goals specified in the performance plan. The "wellness" plan involves detailed analyses of the current situation, identification of causes for the non-performance, and development and implementation of countermeasures. In addition to the station's self analysis, the Compensation and Pension Service should provide "help teams" to stations experiencing workload and performance difficulties to identify problem areas and improvement opportunities. Similarly, four Area Directors will be established in the field to play a strong role in working with poorly performing stations to identify ways that they can improve. If all of those measures fail, VBA will continue to transfer work to high performing stations so that every veteran is provided similar levels of service, no matter where he or she resides in the country.

*Question 3.* Describe how you envision increased specialization within RO's would increase efficiency.

Answer. The Task Force believed that the vast majority of Regional Office employees are executing an extremely difficult and complex task to the best of their abilities. According to the training module developer in Orlando, FL, the VSR position in the current model of claims processing must understand and be capable of performing over 10,900 separate tasks on any given day. Separating the VSRs into distinct functional areas will significantly reduce the number of separate tasks performed on any given day and will allow for greater workload control. Further, concentrating on distinct functional areas, such as development of claims, awards of benefits, public outreach etc., will result in development of expertise of the VSRs in the individual teams. This will lead to higher quality decisions, resulting in less "re-work" thus promoting efficiency and timely claims processing.

*Question 4.* What standards are you going to use to consider the accountability for individual ROs?

Answer. A station's performance will be evaluated on the same criteria that VBA is using to assess the performance of the Director. Those standards include:

- Achievement of monthly rating production goals;
- Improvement in the timeliness of rating decisions;
- Reduction in the number of cases pending over six months;
- Reduction in the number of pending claims;
- Reduction in the number of pending appeals;
- Improvement in the timeliness of appellate remands.

The Directors and their stations also have performance standards for the other VBA programs. These standards are reflected in the balanced scorecard measures for each of the business lines that have operational divisions in a Regional Office.

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RESPONSE TO WRITTEN POST-HEARING QUESTIONS SUBMITTED BY HON. ARLEN SPECTER TO DANIEL L. COOPER

*Question 1.* What are the top three problems within the Veterans Benefits Administration (VBA) that you would like to address? What is your plan to address those problems?

Answer. Based on my experience as Chairman of the Claims Processing Task Force, the three most significant problems or issues that must be addressed are the size of the backlog; the need to maintain high quality decisions while producing large numbers of claims; and the need for greater accountability and consistency in Regional Office operations. A plan for addressing these issues can be found in the recommendations that were submitted by the Claims Processing Task Force. The Task Force recommendations have been endorsed by the Secretary.

The Secretary has made it clear that he wants VBA to reduce the number of pending claims from its current level of approximately 600,000 claims to 315,000 by the end of the year. To achieve this target, VBA needs to continue to meet the monthly goals that have been set for each Regional Office by the Acting Under Secretary for Benefits. The Task Force report included several recommendations that should help VBA achieve and sustain higher levels of productivity. For example, the Task Force recommended that VBA establish specialized processing teams within each Veterans Service Center which will narrow the focus of each employee's job and result in more efficiency in the claims process. These new processing teams are currently being proto-typed in four Regional Offices. Other recommendations in-

cluded consolidating pension maintenance work at three Pension Maintenance Centers and reestablishing phone units, both of which will allow Veterans Service Representatives to spend more time processing claims. Similarly, the Task Force recommendation to have the Board of Veterans' Appeals develop for additional evidence rather than remanding cases to the Regional Office will also free up resources in the ROs to spend more time on new claims.

While VBA has recently made dramatic improvements in the accuracy of its decisions, I am aware of and share the concern that members of the Veterans' Affairs Committees have expressed about the need to maintain quality even with the higher output levels expected of employees. There are several recommendations in the Task Force Report designed to help VBA achieve this objective. One involves a change in the accuracy reviews conducted in the Compensation and Pension Program. These changes will allow VBA to focus on the critical quality issues in a decision involving entitlement, the amount of a veteran's award and the effective date of the award. The C&P Service has increased the number of cases that it reviews so that it can properly assess the accuracy rates for each station. The Task Force also identified the quality of the medical examination process as a critical component of decision accuracy. We made several recommendations to improve the examination request process and the examination process itself. I had the opportunity to visit the Compensation and Pension Examination Project (CPEP) Office in Nashville. CPEP is a joint VHA/VBA initiative to address many of the concerns expressed by the Task Force. My intention would be to fully support this ongoing initiative.

The third issue that needs to be addressed is accountability. Each regional office must know the processes and results expected, and headquarters must be completely aware of the status of actions and processes at each regional office. In order to hold regional offices and their staffs accountable, VBA must first assure that there is nationwide consistency in the business processes, the data processing applications, and the procedures that are being used in the field to process claims. To achieve this, VBA must issue clear guidance in terms of how work should be accomplished along with specific and measurable performance targets. At the same time, VBA needs to establish appropriate monitoring and inspection systems to ensure and measure compliance.

*Question 2.* You have made public your belief that VA cannot now justify asking for additional resources to fix the claims processing system. The President's Budget prominently quoted you to that effect. Do you still hold that view?

Answer. First, I would like to explain that the answer that "no resources were needed" was to specifically address VBA C&P needs at that time (fall 2001).

VBA did secure funding during FY 2001 to support the hiring and training of more than 1,000 new employees. The addition of this many employees in such a short period of time was critical to the Administration's ability to manage the increased workloads resulting from the Veterans Claims Assistance Act and the addition of Type 2 Diabetes to the list of Agent Orange presumptive conditions. A hiring initiative of this magnitude strains VBA's training infrastructure and places a burden on its core of senior-level field employees.

VBA must now continue to focus on maximizing the impact of this hiring and ensure employee retention. As these recent hires are assimilated into the organization and gain experience, I fully expect these employees to make a significant contribution toward achievement of the Secretary's claims processing goals. Essentially, this is a period of stabilization as VBA assesses the recent hiring and training of the new employees and implementation of the Task Force recommendations. I would like to refrain from asking for more FTE until we achieve a more stable situation, which will allow reasoned analysis of our needs.

*Question 3.* The President's proposed budget states that, until a relationship is found between increases in funding for claims processing and the results achieved with that funding, it is impossible to determine the optimal amount of funding for veterans' services. How do you plan to tackle this problem? Do you believe Congress should withhold further funding increases for claims processing until VA establishes a link between performance and results?

Answer. VBA has undergone a tremendous amount of change in the last two years with the hiring and training of 1,000 new employees, the introduction of new technology and business processes to support claims processing, the addition of Type 2 Diabetes to the list of Agent Orange presumptive conditions, and the impact of the Veterans Claims Assistance Act. With these changes came the very large increase in the claims backlog and the establishment of the Claims Processing Task Force.

As I have stated in several forums, VBA is in the process of implementing the Task Force recommendations, which are designed to reduce the backlog. Before VA asks for additional funds for staffing, it is incumbent on the leadership to make an

assessment of the impact all these changes will have on VBA's future productive capacity for processing claims. That assessment cannot be made until the new employees are fully trained and until we can determine how the Task Force recommendations will affect VBA's productivity. VBA has already increased the number of cases it produces each month by a significant margin. This increase is due both to the additional work being done by the recently hired employees as they become more experienced and the result of the establishment of very clear production targets for each of the Regional Offices. These standards have been incorporated into the performance requirements of the Directors.

As VBA rolls out the new specialized teams in the Veterans Service Centers, I expect to see even greater gains in productivity. By the time the next budget cycle rolls around, I would expect VBA to be in a better position to determine its staffing needs based on a sound assessment of its productive capacity in relation to its future projected workload.

*Question 4a.* Secretary Principi has staked the success or failure of his tenure as Secretary on the improvement of the claims system. He has established aggressive goals to achieve improvement by the summer of 2003. Am I correct in assuming that the plan to achieve those goals is outlined within the VA Claims Processing Task Force report? If so, I have several questions relative to the Task Force recommendations.

Answer. You are correct that the plan to achieve the Secretary's goals for the improvement of the claims system is outlined in the Claims Processing Task Force Report.

*Question 4b.* The Task Force concluded that accountability was the single greatest deficiency within VBA. Congressionally-mandated reports dating back to at least 1996 highlight the same deficiency. It would seem that although the problem has been well-identified, the will to remedy the problem has been lacking. If you are confirmed, how will your efforts to hold individuals accountable differ from past efforts? What does accountability mean to you?

Answer. Before you can hold a Director or any employee accountable, you have to first establish clear and measurable performance expectations. As a result of the Task Force's focus on this issue, VBA has established performance requirements for every Director that are tied directly to the Secretary's priorities. Specific service delivery goals have been set for: monthly rating production, improvements in processing times, reductions in the number of cases pending over six months, reductions in the total pending inventory of claims, reductions in the number of pending appeals, improvements in remand timeliness, and timeliness standards for putting cases under control in VBA's data processing systems.

The Directors' performance plan also states that if any of the service delivery goals are not met, the Director is required to submit compelling mitigating reasons why the goal was not met and identify actions that are being taken to improve the performance.

"Wellness" plans have already been requested of some station Directors who have, thus far, failed to achieve the goals specified in the performance plan. The "wellness" plan is a detailed analysis of the current situation, causes for the nonperformance, and development and implementation of countermeasures.

National performance plans have also been developed for the first time for Rating Veterans Service Representatives and Veterans Service Representatives. The plans address both production and accuracy standards. Directors are also expected to establish complementary performance requirements for all of their managers and supervisors that support the organization's ability to meet its goals.

Accountability to me means not only being the person considered "in charge" or responsible for the actions and results of the group, but also being knowledgeable of the actions of subordinate groups. In this case, it means not only directing 57 regional offices, but also knowing what actions they are taking, what results they are achieving, and why they may or may not be successful. My intention is to have direct, frequent, and substantive communications with regional office directors. There will be little doubt of my expectations and my strong desire to help them be successful.

*Question 4c.* The Task Force made a short-term recommendation to consolidate pension maintenance functions. VA has begun to implement this recommendation. However, I also see a long-term recommendation to contract out pension maintenance functions. Why would you have recommended contracting out pension maintenance before VA has an opportunity to learn how consolidation within VA is working?

Answer. Task Force recommendation S–9 includes the development of "a prototype for the competitive sourcing of pension claims processing with a demonstration contract in FY 2002." Action on this part of the recommendation has been deferred

until July 2003. VBA must assess the impact of the pension maintenance consolidation initiative, which will not be fully implemented before end of year 2003, before proceeding with this recommendation. After full implementation of the pension consolidation initiative, weaknesses that continue in the system can be identified and analyzed. At that time, VBA will assess the need for competitive sourcing of pension claims processing.

*Question 4d.* Your Task Force envisioned increased work specialization across VA Regional Offices (110s), recommending that some ROs do more complex rating work while others do less complex claims maintenance or public outreach work. How will you identify the ROs which will specialize in each type of work? If, as the Task Force recommends, underperforming RO's will be targeted to specialize in less complex work, haven't you predetermined the necessity for some ROs to fail so that the specialization scheme works? What opportunity will you give underperforming ROs to turn things around before denying them resources and assigning them less complex work?

Answer. What I would call "judicious use of specialization" can be an effective technique to increase productivity and help foster consistent treatment of similar claims. This specialization can be accomplished at a couple of levels.

At the Regional Office level, the Task Force Report recommends the establishment of specialized teams within the defined claims processing functions of Triage, Pre-determination, Rating, Post-determination, Appeals, and Public Contact. Four stations (Milwaukee, Reno, San Diego, Roanoke) are now piloting this recommendation. National implementation will be complete by mid-fall.

VBA has also taken action on the Task Force recommendation to designate specialized Regional Offices to work specific tasks. Spina Bifida claims and claims for disabled children of female veterans are now consolidated in the Denver VARO. On a larger scale, VBA began to consolidate pension maintenance activities into three centers located at the Regional Offices in Milwaukee, St. Paul, and Philadelphia. As a result of another Task Force recommendation, claims for older veterans that are over one year old and frequently involve complex development issues are being processed by the Cleveland Tiger Team.

While there are several factors to consider in selecting a site for specialized activities (including the availability of space and the ability to recruit), the primary factor will be performance. Stations that have established track records for high performance will be considered first in any decision to consolidate or to perform specialized functions.

As recommended by the Task Force, VBA has revised its resource allocation model for this fiscal year. The focus of the recommendation was to have a cohesive strategy for getting resources to the stations that can most effectively address VA's national workload challenges.

Stations that are not performing up to expectations are being asked to develop "wellness plans." The "wellness plan" provides a detailed analysis of the current situation, causes for non-performance, and countermeasures to improve performance. In addition to the station's self analysis, the Compensation and Pension Service should provide "help teams" to stations experiencing workload and performance difficulties to identify problem areas and improvement opportunities. Finally, four Area Directors will be established in the field to play a strong role in working with poorly performing stations to identify ways that they can improve. If all of those measures fail, VBA will continue to transfer work to high performing stations so that every veteran is provided consistent service levels levels no matter where he or she resides in the country.

*Question 4e.* What role do you envision veterans' representatives playing once you specialize functions among Regional Offices? If a veteran's claim is sent to a remote Regional Office, how can that veteran's representative remain involved with the claim?

Answer. Veterans' representatives will continue to play a vital role in claims processing. VBA is continuing training of the representatives in the TRIP (Training, Responsibility, Involvement and Preparation of Claims) Program. Through this program, representatives are trained and given access to computer applications that provide information for their clients and that will help them help veterans. They will have access to this information, regardless of where the claim is sent for processing. As new computer programs become available, the veterans' representatives will be trained in use of these programs in order that they may better assist veterans, regardless of the location at which the claim is being processed.

*Question 4f.* The Task Force highlights the inordinate number of days it takes to establish a computer record on a newly-filed claim. Why does it take so long? The Task Force goal is to bring the number of days down to two. How will you accom-

plish this? How will you account for time delays resulting from claims being sent from one Regional Office to another?

Answer. The reason for the delay in getting new claims under control was simply that the function was not a management priority. It was one of a multitude of tasks that were assigned to the Veterans Service Representatives and the relatively small cadre of clerical staff that exists in each office. The new processing model developed by the Task Force includes a Triage Team whose primary function will be to review all of the mail and to get claims under control in two days.

VBA has already taken some initial steps to improve the timeliness of this process by including a standard in the Directors' performance plan that requires stations to put 70% of new claims under control within 7 days. The 70% factor was added to account for the time delays associated with transferring cases from one jurisdiction to another. This standard will be dropped to 2 days when the new specialized processing teams are implemented throughout the country. In addition, an automated system is being developed that will provide the date that a claim is received by a second station. The receiving station will have two days from this date to put the case under control. The new claims processing model is currently being prototyped in four stations. VBA expects to deploy the process throughout every Regional Office by mid-fall.

*Question 4g.* The Task Force recommends establishing a prototype site for outsourcing the claims development function. When do you envision implementing this recommendation? What, in your estimation, would be the impact on VA employees if you were to outsource this function?

Answer. The Task Force did recommend a prototype site for outsourcing claims development. In order for us to make an equitable comparison between VA and a private contractor, full implementation of the Pre-Determination Team in the new model will have to be completed. Further, because of the complexity of the process and the various regulatory and manual requirements, the Task Force believed that this outsourcing could not be implemented until the regulatory and manual rewrites are completed. Any outsourcing action would have to also determine the impact on VBA employees. This recommendation is a very low priority and I do not have a thought on a possible time frame for implementation.

*Question 4h.* A number of Task Force recommendations touch on collaborative efforts that need to be conducted with the Board of Veterans Appeals and the Veterans Health Administration. How will you ensure that those organizations cooperate with what you're trying to accomplish?

Answer. BVA and VBA began collaboration on February 25, 2002, with a team of eight BVA personnel and three VBA personnel. Jointly, they are developing for evidence on appeals, rather than remanding appeals back to the field stations to be developed. The VBA personnel also do ratings and awards on appeals at BVA when a partial grant of benefits results from a BVA decision.

The Compensation & Pension Examination Project (CPEP) is a VBA and VHA collaborative project to improve the quality and timeliness of C&P examinations.

*Question 4i.* The Task Force report criticizes VA for its unrealistic assumption that the claims processing workload would remain static and not be affected by events like future military conflicts and changes in legislation. Are you aware that the Fiscal Year 2003 budget request assumes that workload will not be dramatically affected by a major national security emergency within the next five years? Do you think this is a reasonable assumption given the present state of world affairs?

Answer. The assumptions for the FY 2003 budget cycle were originally formulated in FY 2001. While there may have been some opportunity during the FY 2003 OMB passback process to make changes to our assumptions, at that point the military actions in the war on terrorism did not warrant changes. We will continuously monitor the situation and advise you if we foresee increases in our resource requirements as a result of the war. For the FY 2004 budget submission, our assumptions will include such factors as appropriate.

*Question 5.* From fiscal year 1997 through fiscal year 2001, VA's total claims workload declined 19% and VA's rating-related claims workload declined 6%. However, personnel dedicated to handle the workload during the same time period increased 30%. In your judgment, why has performance not improved commensurate with the resources provided? Do you believe VA is "turning the corner" on reducing backlogs and processing times?

Answer. I am aware that VBA substantially increased its staffing levels over the past 5 years. However, in 1997 the staffing levels were at the lowest level since 1990, dropping 14% in just two years, from 1995 to 1997.

The average workload decline from 1997 to 2001 was in the range of 1–2%. Although the data shows a more significant decline in 1998 and 1999, this decline was due to several factors. VBA reduced the release of several internal control reviews

such as dependency questionnaires, social security number verifications, income verification matches and eligibility verification reports.

In 1998, VBA began the major realignment of the Adjudication and Veterans Service Divisions. This realignment involved extensive training hours. Even

though VBA gained resources during this period, the training hours dedicated to mentoring these new employees (to include classroom instruction) augmented an already intense training effort. At that time, VBA was cognizant that it took an average of 2–3 years for an employee to reach journey-level status.

VBA was also developing several information technology (IT) tools that would accelerate the data exchanges, reduce routine data entry and award generation as well as provide claim status information to service organizations. These efforts demanded a lot of time from experienced decision-makers in both rating and authorization.

Finally, VBA was faced with absorbing the impact of the increased complexity of decisions due to the changes in legislation and Court decisions, an increase in the number of issues per original claim, and the fact that prior staffing levels did not allow VBA to absorb those impacts.

I believe that with the implementation of the recommendations of the Claims Processing Task Force, VBA has the opportunity to turn the corner on reducing the presently very high backlog and processing times. VBA is carefully monitoring the monthly performance and workload levels to assess the progress. This careful monitoring will allow VBA to proactively effect change whenever anomalies are identified in the data or workflow. As recommended by the Task Force, VBA is now focused on a few IT efforts that will eventually benefit the organization and the veteran.

*Question 6.* Your predecessor recommended that the Committee look to a "Balanced Scorecard" to gauge performance. What performance measures should the Committee look at when evaluating whether the claims processing system is improving under your leadership?

Answer. VBA continues to use the balanced scorecard as the composite approach to measuring performance. The first page of this tool identifies the measures that can be readily used to assess the level of national performance. The scorecard has been enhanced to include a "page 2," which identifies more discrete, operational measures that contribute to performance improvements. Focus on these operational measures will facilitate identification of processing vulnerabilities and rapid development of management corrections. Comparison back to the corporate scorecard measures will validate management successes.

*Question 7.* Your predecessor resigned in the aftermath of multi-million dollar fraud case in which current and former employees stole money by "resurrecting" disability claims of deceased veterans and having the proceeds sent to themselves. What will you do to prevent—and detect—other cases like this from occurring? If you are confirmed, would you do anything different than what is being done now to prevent fraud?

Answer. VBA has taken a number of actions to minimize the possibility of employee fraud. I would continue to implement the procedural and systematic changes necessary to improve VBA's internal controls. Most important will be the increased accountability of managers to ensure that proper procedures are followed. The VA Claims Processing Task Force found that "accountability—is the most serious deficiency in the VBA organization."

Based on the recommendations of the Task Force, VBA is enforcing more accountability for managers, particularly in the areas of internal controls. For example, Directors' performance standards were revised for FY 2002. A number of specific performance expectations were added or strengthened. The performance element of Program Integrity, which covers areas such as OIG findings, is a critical element.

As of August 2001, Directors or their Assistant Directors are required to personally review all Compensation and Pension payments over $25,000. They receive notification by email on a bi-weekly basis and must complete and return the review within 15 days. Any deficiencies found are reported to VBA's Office of Program Integrity.

The Office of the Inspector General (OIG) recently visited all regional offices to conduct a review of large one-time payments for the period January 1996 through August 2001. The areas of review included the security of employee folders and employee access to sensitive files. OIG examined several IT security areas, identifying deficiencies that required corrective action. Regional Offices are currently making those corrections. Additionally, VBA requires special analyses of these deficiencies to include why they were found and details of the corrective actions being taken to prevent future discrepancies.

To identify "suspect" claims below the $25,000 threshold, VBA recently completed a data mining Pilot utilizing proven commercial technology and applying statistical

analysis techniques to the C&P benefits payment process. Currently, VBA is evaluating available Data Mining technology.

Finally, VBA is enlarging and expanding its Office of Program Integrity. This office will be responsible for working with field stations, VBA program offices, and other VA organizations, such as the OIG. I support the recent VBA efforts to strengthen program integrity. I intend to work to expand and improve the VBA internal controls systems, to resource those efforts fully, and to steadily diminish risk of fraud and mispayment in our delivery systems.

*Question 8.* Congress has made significant improvements to Montgomery GI Bill (MGIB) education benefits in recent years. Do you have a view as to the appropriate level of assistance Congress should provide as an MGlB benefit? Do you support equalizing, with MGlB benefits, education benefits afforded to spouses or dependent children of service members and veterans who die as a result of service-connected causes?

Answer. Each year the College Board determines the average cost for a commuter student to attend a public four-year education institution. Consideration should be given to increasing the VA Education Program rates to equal this amount each year.

Last year increases were authorized for spouses and dependent children attending school under the Survivors' and Dependents' Educational Assistance Program (known as DEA). Action was also taken to tie future rate adjustments to the Consumer Price Index (CPI). The current full-time DEA rate is $670 per month. The full-time rate for IVIGIB claimants with a two-year period of service is $650. For an IVIGIB claimant with a three-year period of service the full-time rate is $800 per month. The action that was taken to tie future DEA rate adjustments to the CPI will insure appropriate adjustments continue. Therefore, in my view, no further action is necessary.

*Question 9.* Since Fiscal Year 2001, processing times for MGIB benefits claims have worsened. What is your plan to improve MGlB benefit processing times?

Answer. Performance improved significantly during the first five months of fiscal year 2002, when compared with the first five months of fiscal year 2001. The following table shows the average processing days for each month:

| | Supplemental Actions | | Original Claims | |
|---|---|---|---|---|
| | FY 2001 | FY 2002 | FY 2001 | FY 2002 |
| October | 27.71 | 23.98 | 49.73 | 43.75 |
| November | 20.88 | 17.44 | 55.73 | 43.58 |
| December | 21.88 | 18.37 | 63.66 | 39.71 |
| January | 25.19 | 17.03 | 58.78 | 38.50 |
| February | 23.50 | 14.50 | 50.16 | 33.90 |

Several actions contributed to this improved performance:

- Adequate overtime was authorized earlier in the fall and was focused on achieving production targets.
- Seasonal employees were hired to perform certain tasks during peak periods, allowing station managers to shift their experienced staff to claims processing.
- In anticipation of an increased workload, VA hired over 100 new employees to handle education claims last year. These new employees have received training and gained experience, resulting in increased per capita output and improved timeliness.

I would expect to continue to appropriately target overtime and use seasonal employees during peak enrollment cycles to effectively manage the education workload. In addition, enhancements to the Enrollment Certification Automated Processing system (ECAP) are being developed that will allow more cases to be processed without human intervention. ECAP is a proof-of-concept prototype that uses "expert" or rules-based systems to process claims in an automated environment. At this point, only 3–4 percent of all incoming work is completely processed in this way. A more sophisticated rules-based application will allow many more claims to be completed without human intervention.

*Question 10.* The Federal Housing Administration (FHA) provides some federal home loan benefits that are not available exclusively to veteran under VA's home loan program. As a general principle, do you support enhancing the benefits provided under VA's loan program so that veterans have loan options at least as attractive as those available to non-veterans through FHA?

Answer. As a general principle, I favor enhancing VA's home loan program to give veterans the same options non-veterans have under the FHA program.

RESPONSE TO WRITTEN POST-HEARING QUESTIONS SUBMITTED BY HON. LARRY E. CRAIG TO DANIEL L. COOPER

*Question 1.* What are some of your ideas for improving the VA Education program?

Answer. Each year the College Board determines the average cost for a commuter student to attend a public four-year education institution. Consideration should be given to increasing the VA Education Program rates to equal this average cost each year.

Public Law 107–103 provided for accelerated payments for education leading to employment in high technology industry starting October 1, 2002. VBA will evaluate the response to this program to see if it should be expanded to other types of courses as well.

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RESPONSE TO WRITTEN POST-HEARING QUESTIONS SUBMITTED BY HON. KAY BAILEY HUTCHISON TO DANIEL L. COOPER

CLAIMS PROCESSING BACKLOG

*Question 1.* The report of your task force looking into the VA's claims process revealed many areas of potential improvement. What is your vision for implementing these recommendations and what stumbling blocks do you foresee?

Answer. Implementation of the Task Force report was begun in earnest last fall when Judge Guy McMichael became acting Under Secretary for Veterans Benefits and Stanley Sinclair became his acting Deputy. Both of these men had been participants in the Task Force deliberations and had strongly supported the Report.

In my opinion, the implementation process they began is the best I have seen and it far exceeds any implementation done after the previous several VBA studies completed in the last decade.

Each recommendation has been evaluated, grouped where appropriate, delayed if considered of low priority or low return, and effectively planned with timelines developed. Each month reports are made to the Secretary and Deputy Secretary of Veterans Affairs.

I see no stumbling blocks. There may be some diversions and accommodations, and every single recommendation may not be implemented as stated—but every one will be studied and properly judged. Each one to be implemented will be measured and tracked until completed.

Senator ROCKEFELLER. Senator Graham, I was just suggesting that I have a whole series of questions. If you and Senator Nelson want to start off with questions, I would be more than pleased by that.

Senator GRAHAM. Thank you very much, Mr. Chairman.

Dr. Roswell, to pick up on a comment that Chairman Rockefeller made in his opening statement relative to the issue of long-term care. As our veterans population grows older obviously that will be at heightened demand. From your experience in a state with a large population of older veterans, how have you proceeded to try to meet that demand and what would you now suggest at a national level be the policy at the VA?

Dr. ROSWELL. The long-term care needs of America's veterans are significant. I don't believe those needs can be fully addressed with a single level or program of care. Certainly, VA needs to continue its efforts to build its staffed nursing home care capability. But probably more significantly, VA needs to seek alternatives to institutional care.

We need to partner with the State Department of Veterans Affairs to improve and enhance the State veterans home nursing capability. But we also need to seek home care programs; programs in the community, adult day health care programs.

In Florida we have a very innovative program with over 1,000 veterans receiving care through interactive technology in their very

home. This has greatly enhanced care. It has actually reduced nursing home placement by almost 80 percent at a cost savings of approximately 75 percent for veteran served.

I believe there are many innovative opportunities and will certainly look forward to working with this committee and the chairman to try to meet those needs, not only in Florida, but around the country.

Senator GRAHAM. Doctor, one of the fastest growing areas in terms of VA health services have been the Priority 7 veterans. These are non-service connected disabled veterans who have income levels of $24,000 a year or above. The growth rate in Priority 7 veterans in terms of accessing health care has been approximately 30 percent annually for the last 6 years. So, it is a very rapidly expanding group of veterans.

The President has recommended that there be a $1,500 annual deductible for the Priority 7 veterans. Others have suggested closing off enrollment for Priority 7 veterans. What options do you think we ought to consider for the Priority 7 veteran?

Dr. ROSWELL. Well, while I am obliged to support the President's budget——

Senator GRAHAM. I hope we don't have a repetition of the Corps of Engineers here.

Dr. ROSWELL. Thank you, sir. I would point to Secretary Principi's testimony before this committee, that he believes the $1,500 deductible is one option to defray some of the cost of care for Priority 7 veterans, but there are other options.

Clearly VA needs to be as efficient as we possibly can in the use of appropriated resources. To compliment those appropriated resources, we must do a better job of enhancing our recovery from private insurance companies where that is authorized by law.

Having said that, I think we need to examine the health benefits. It is my belief that many of the Priority 7 veterans are currently Medicare beneficiaries who are attracted to the prescription benefit within VA. I believe we need to examine both the incentives and the economics in order to fully understand the situation and begin to work toward a solution.

Senator GRAHAM. Your last comment about the attractiveness of the VA prescription benefit, do you have an idea of how much of the health care services delivered to Priority 7 veterans have been in the pharmaceutical area as opposed to other health care services and products?

Dr. ROSWELL. I can't give you a specific amount, Senator. I would be happy to get back with you. We do know that the average cost for a new Priority 7 veteran, the first year of care, is less than what we would expect for a typical veteran. It is on average around $1,000.

Many of the veterans who are Priority 7 veterans who are new to our system expressly state that they are seeking prescription benefits through VA's attractive $7 co-payment. I do believe that is a significant factor in the large number of Priority 7's now using the VA for care.

Senator GRAHAM. I'll ask one more question.

A number of members of this committee were instrumental in the establishment of the VERA model which has as its goal to pro-

vide equality of treatment in terms of health care resources for the veteran, wherever that veteran might live.

Could you give us your assessment of how well the VERA program is working and are there any areas of refinement that you would recommend we consider?

Dr. ROSWELL. I believe that the VERA model has done a laudable job of what it was intended to do. However, we face a dynamic veteran population and as the veteran population and the demand for care evolves so must the VERA model. Each year the VA has reexamined that VERA model and has made adjustments, including adjustments this year to refine that model.

Currently VA is evaluating the applicability of the model to the Priority 7 veterans that you spoke of which previously have not been funded through the VERA process. We are also examining the way the model adjusts for case mix in the most costly patients. I am committed to the concept behind VERA, but believe we must continue to work and refine the model to make sure that it continues to meet both current and future veteran's needs.

Senator GRAHAM. Thank you, Mr. Chairman.

Chairman ROCKEFELLER. Thank you, Senator Graham.

Senator Nelson.

Senator NELSON of Nebraska. Thank you, Mr. Chairman. Dr. Roswell, I was impressed with your comment and your written testimony that states regarding VISN's that the time has come to maximize performance and minimize variation across the Veterans Integrated Service Networks.

We currently have an issue regarding the merger or integration of VISN's 13 and 14 and we are scheduling a field hearing in Nebraska to deal with that, plus raise some questions about Priority 7 benefits and deductibles. In the process of doing that, I know that the Secretary has indicated a desire to come appear at the hearing, but I realistically understand schedules and I would like to begin by extending you're an invitation, if it would work with your schedule, to perhaps join with us at that field hearing.

But my question today goes toward the funding of legislation for the year 2002. Congress required that the VA maintain an open access policy for veterans with schizophrenia who need a typical antipsychotic medication. As a matter of fact, the language requires the agency to inform each VISN that anti-psychotic medicines ought to be chosen based solely upon the best clinical judgment of VA physicians as opposed to the process and procedure in place before that excluded certain kinds of medications and favored other medications quite apart from what the clinical judgment of the VA had.

I wonder if you might inform the committee. I am interested in this in an individual way, but the committee probably has an interest in it as well about what steps VA is taking to ensure that the open access policy is in fact open and is being properly implemented.

Do you have monitoring systems that are in place? Can we get a report? Is there something that you can report to us even today based on what you may know already?

Dr. ROSWELL. Well, thank you, Senator. It would be my distinct privilege and honor to appear at the field hearing when that is scheduled.

With regard to the prescribing of atypical anti-psychotics, there is compelling scientific and medical evidence suggesting that the use of atypical anti-psychotic agents in the management of chronic mental illness reduce the requirement for hospitalization.

We have studied this in some detail in Florida and know for a fact that when there is a higher prescribing rate for atypical anti-psychotics that we actually reduce hospitalization and the overall cost of care, not to mention enhancing the quantity of life for those veterans who suffer serious mental illness.

That information is available. I think the open access issue centers around whether an atypical anti-psychotic should be used. Clearly one should be used when it is indicated.

There is also an issue of cost. Several of these agents have a similar efficacy. They do essentially the same thing but they may vary significantly in cost.

With regard to the use of one of the atypical anti-psychotics in patients who carry a diagnosis of schizophrenia, by using our current data base we are able to determine that. The numbers show that a substantial majority of veterans who have that diagnosis are currently receiving an atypical anti-psychotic agent.

We would be happy to followup with more specific information.

Senator NELSON of Nebraska. So, you are tracking to see whether or not it is open access and then also in the results that the patients are having as part of the consideration for continuing to prescribe these kinds of medicines.

Dr. ROSWELL. Yes, that is possible using the robust nature of VA's electronic medical record data base. We can track that and in fact do track that.

Senator NELSON of Nebraska. Thank you. Thank you, Mr. Chairman.

Chairman ROCKEFELLER. I have a series of questions. I will start with you, Dr. Roswell.

There is no secret that the health care system as a whole is experiencing budget shortfalls. The problem is that we are really under spending limits. We have to live within our means.

You have 27 outpatient clinics in your network.

I find that clinics are an enormous conduit to get veterans into the VA health care system, which is what I want to see—not just to keep our hospitals busy but so that they get the health care which they need.

Committee staff actually called each of these 27 outpatient clinics in the last several days. They found that only one of those clinics is now seeing new patients without an extensive waiting list. I think that says a lot. Veterans want in. These clinics are speaking to them in very strong ways.

Asking you how many new patients have these clinics brought into the system, and what kind of effect has that level of demand had on your corner of VA is probably not an entirely fair question to ask at this point, but I am going to ask it anyway. There are some who say that every time you open up a clinic all you are doing is burdening the system.

You are spending money, which means you have to take it away from somewhere. I am interested in your thoughts on the clinics.

Dr. ROSWELL. Well, Mr. Chairman, I certainly echo your support for clinics. I believe that providing care in non-institutional settings across the gamut of health care services is a very desirable strategy. On my opening remarks I mentioned that I believe the next major transition in health care will be taking care more significantly into the home environment. So, I do support that.

We have had a tremendous growth in demand for care in Florida and certainly the creation of community based outpatient clinics has spawned much of that demand, as has the new eligibility legislation which became effective in October 1998.

Currently, there are over 405,000 veterans receiving care in Florida compared to about 225,000 receiving care each year when I went to Florida as the VISN Director in 1996. So, there has been an 80-percent increase in the total number of veterans receiving care.

I believe that each and every one of those veterans is entitled to that care by their military service. As a person who has dedicated my life to caring for veterans, I have done everything I can to make that care available. I do think it is important that we do everything we possibly can, to make that care as efficient as possible. I believe there are still opportunities to improve the efficiency of the care we deliver. We are diligently working to achieve those efficiencies this year and we will be continuing to do that.

Chairman ROCKEFELLER. Often clinics are just a couple of people—a couple of rooms in a little building on the corner of the street. So, achieving efficiencies is difficult. What are some examples of how you would do that?

Dr. ROSWELL. Some of the ways clinics can be efficient, include the way they manage patients and the way they refer patients to the parent medical center, and the way we use technology to take expertise to the clinic. For example, telemedicine can bring psychiatric or mental health care into a primary care clinic where the only physician may be a primary care generalist.

I think technologies can reduce the travel time and can reduce the use of specialty resources by using automated practice guidelines and clinical reminders that we can place on the computerized patient records system. We can impart more knowledge and decision support to the clinician in a remote, isolated setting.

We can achieve efficiencies in the way we provide pharmaceuticals utilizing mail-out pharmacies. There are a variety of ways, even in the community clinic setting that we can become more efficient.

Chairman ROCKEFELLER. Thank you. Let us look again, Dr. Roswell, at the situation in St. Petersburg and Beckley, WV.

Now, here is a true story: A West Virginia veteran spends time in Florida for the winter. While he is there he receives care at one of these clinics, but after some tests he is told, "We don't have enough physicians to follow your care on an on-going basis. You have been placed on a waiting list along with more than 2,200 other veterans."

Now, the veteran's doctor in Beckley is told that even though the veteran is in Florida, it is his problem to care for him. While this is obviously a budget issue, it is also a management issue. I don't think that we are doing right by our veterans. I don't know exactly

how to fix a situation like that and to be honest with you, I can't tell you how common that is.

But if it happens to one of my veterans once in my State, I am going to make it into an international case before the Security Council of the United Nations.

How does something like that come about?

Dr. ROSWELL. I think it is probably not terribly difficult to explain. A veteran receiving primary care in Beckley, WV should know their primary care provider. If that veteran plans to spend a significant amount of time out of State, in Florida, let us say, during the season, it would be usual and customary for the veteran to arrange with the primary clinic to provide the medications needed.

Chairman ROCKEFELLER. In Beckley?

Dr. ROSWELL. Correct. That is the policy that is advocated by the pharmacy service here in our VA central office. It is a policy that is generally adhered to around the system.

Chairman ROCKEFELLER. It is one thing if it is prescribing prescriptions. I want to understand how the care part works.

Dr. ROSWELL. That part, is what we try to make available. We would expect that chronic routine medications be provided by the primary physician responsible for the veteran's care. But if there were any type of urgent or emergent need or interval check that would be required, that should be provided.

We have made a tremendous screening effort with veterans waiting to receive care throughout the clinic locations that you alluded to in Florida to identify any urgent or emergent need for health care and make that available.

But by taking a veteran who needs to be seen or may have an interval illness that requires supplemental medication, we want to be able to provide that evaluation, provide that care, provide the needed medication. But that is not necessarily tantamount to enrolling that veteran into and assigning him to a new primary care provider, which would duplicate their primary care physician in Beckley, West Virginia.

Clearly, we need to have better coordination, though.

Chairman ROCKEFELLER. Because when they said 2,200 people on a waiting list that wouldn't apply to Beckley. That is kind of a Florida figure.

Dr. ROSWELL. The 2,200 sounds like that particular clinic. In Florida, we have over 30,000 waiting to be assigned to a primary care provider.

Chairman ROCKEFELLER. Oh, really?

Dr. ROSWELL. That's correct.

Chairman ROCKEFELLER. Well, then, let me ask about that.

Dr. ROSWELL. As I said, it is a significant issue. Most of these veterans are veterans who have newly enrolled in VA. Over 55 percent of them are Priority 7 veterans who are seeking supplemental benefits to augment the care they currently receive. We do make sure that they are offered enrollment. We process the enrollment forms. We screen them for any emergent need for care. If they need emergent care, we provide that emergent care. If they need to be seen more quickly than the waiting list that a particular location allows, we will refer them to a facility where there are not such

lengthy waits which is usually the case in our metropolitan medical centers.

But assignment to a routine primary care provider unfortunately can take many, many months, given the current resource constraints we are struggling with.

Chairman ROCKEFELLER. Describe to me, as you understand it, those resource contraints with respect to the 30,000 waiting for care in West Virginia. I assume that figure can be broken down into those who would require much more attention than others.

Like a veteran with PTSD. Or a veteran with a spinal cord problem. What kind of shortage or lack of doctors and nurses did you face, because of budgetary constraints?

Dr. ROSWELL. I do understand, I believe, sir. I think the comprehensive needs of most veterans are being met. The veteran with the more complex care requirements, the veteran with the spinal cord disability, the veteran with catastrophic medical illness would typically fall into a higher priority.

What we find is that the overwhelming majority of those veterans who chose to use the VA are already receiving care. When we typically open a new primary care of community-based outpatient clinic, the new users are generally healthy veterans, typically Priority 7 who have an alternate provider who are seeking to augment their current health care with prescription benefits or care that is more conveniently provided in their local community.

Many of those veterans don't have the complex conditions, which is probably why the cost of care is substantially lower for this group of veterans. The resource constraints we face are primary care physicians.

As you pointed out earlier, a typical community clinic might include one primary care physician, one or two advanced practice nurses and three or four support staff.

There is a finite limit of how many patients a physician such as that can safely care for. What we are trying to do now is to maximize the efficiency to increase the number of veterans a primary care clinic is able to handle, but do that in a way that doesn't require us to hire additional staff that our current budget doesn't support.

Chairman ROCKEFELLER. My driving force over the years has been health care. For the 500th consecutive year, we are trying to pass a prescription drug benefit. The cost of that ranges all the way from $190 billion to $850 billion.

I just pray that somehow we can come together and get something done this year. If we passed a Medicare prescription drug benefit, what would be the effect on the waiting lines for appointments?

Dr. ROSWELL. It would only be speculation on my part. Clearly there would be an impact. I think the challenges, VA as a health care system faces today exactly mirror the challenges this Nation faces in its health care delivery.

We don't have an effective prescription drug benefit for older Americans. As a Nation we don't provide comprehensive long-term care and end-of-life care program benefit for older Americans.

Those are the very same challenges VA is facing. Because VA is attempting to provide in a comprehensive manner those prescrip-

tion benefits and long-term care benefits, increasingly that makes VA health care more attractive to veterans entitled to that health care system.

Chairman ROCKEFELLER. You left out mental health, at least in my judgment.

Dr. ROSWELL. I would agree with you.

Chairman ROCKEFELLER. This is to Mr. Cooper. Let us suppose that you are confirmed and complete a full term in your position. Here is the kind of question I hate being asked, but whenever I am it makes me think in ways that I otherwise wouldn't.

In 2006 when your term would be completed, what will you be able to say or what would you want to be able to say was accomplished during your tenure in the VA? I want you to think about that.

Mr. COOPER. What I would hope to be able to say is that the VBA regional offices were operating essentially in the same way, using the same processes, using the same IT and coming out with consistent results.

I think the second part of that, although tied to it, would be that we had increased, at least in my eyes, the accountability that everybody within VBA felt for accomplishing the work that we needed to do.

Chairman ROCKEFELLER. That is a good answer. What are the impediments for that? You have dedicated people. But you also have a lack of uniformity in decisionmaking and you have insatiable and understandable demand for services. Since claims may be held up for months, in their hearts some veterans feel like they have been ignored by their country, their service forgotten. So, you have not only a personnel and succession issues to get through. You have financial challenges to get through. You have a technology gap to get through. But you also have a psychological challenge to overcome. That is hard to do.

It is easy to say that you can go around and go to every VBA office and boost morale. You see new technology and you feel great as you walk out thinking the world is going to change. But it never quite does. It never quite does.

Recognizing that this is the second largest agency in the U.S. Government, do you see yourself being able to achieve your goals and to do the kinds of things which would be required to achieve them. When Secretary Principi was being confirmed, I used my "in your face" line of questioning.

Basically, I was saying, "Would you be willing to go face to face with the President of the United States if you felt that you weren't getting the budget you needed for benefits, for health care, for all the things in the VA system." He said, yes, he would. I believe him. I believe he would.

So, I am looking for that kind of "in your face" attitude from you with the people that you must work with, you know what I am saying.

Mr. COOPER. Yes, sir. And I go back to accountability. I really go back, quite frankly, to my own background in nuclear submarines because there is no more focused group than the submarine force as far as how they operate and what they do.

I quite frankly use that as a model because I could go from one submarine to another and I could tell you how that ship was operating because they were always operating within certain parameters.

I knew where things were on the ship and they knew what the procedures were that they carried out. Was there deviation? Of course, each ship operated slightly differently. That's my goal, not that everything is cookie-cutter. But the fact is there are certain basic things that we have to be doing in every RO to accomplish the quality, the accuracy, the timeliness that we need.

If we aren't doing those in every RO, how can I possibly tell what corrections can be made to the whole system? If everybody is doing it completely differently, it is difficult to tell what you can do to help the whole system. So, I would merely tell you that the primary component of this is accountability and they have already started making sure that people realize the things for which they are accountable and that people are being measured.

Chairman ROCKEFELLER. That was a very good example, to carry over the intensity of what you find in the life of a submarine. That is a good answer. That is what I would wish for you then, that intensity, that command, pressure, coordination, no room for mistakes, will dominate your thinking on this.

Mr. COOPER. They are still people out there. Everybody is a people and we have to understand that. The people understand the guidelines that they are supposed to follow and if they don't want to or feel that they can't follow those, fine. Then we will allow them to do something else.

But it is important that everybody understand what the parameters are within which you have to work because this is so important. We can't have everybody doing their own thing.

Chairman ROCKEFELLER. How do you say that to them; that if you don't do this, you know, maybe you have Civil Service protection, but you are going to be doing something else.

That is a very powerful tool that a manager has and it is often not exercised because the other place where you would have that person go already has somebody in it or something of that sort. I mean that is a powerful concept.

Mr. COOPER. I would say to you that one on one, as you look them in the eye, you say, look, this is my vote. We aren't voting today. The vote is in. This is what we are going to do.

Now, that doesn't mean you have cutoff communications. That doesn't mean you don't listen to other ideas, but when the dye is cast, then that is what we are going to do. So, quite frankly, I think you do it by eye in this particular position, communicate personally with the RO directors.

Again, I go back to the only model I know from my years of experience in the Navy, namely the submarine. When I was commander of the submarine force in the Atlantic, every commanding officer that came through, I talked to him personally for a specific amount of time. I would go to sea once a month, on a different ship each time, and I had communications with them. That, in fact, is the only way I know.

Quite frankly, I have a letter that will go out to all the regional office directors that says, here are some of the things I want you

to think about and, by the way, you and I are going to have some direct communications. I will be sending you letters and you can feel free to send me letters.

I want them to feel that I am knowledgeable about what they are doing, and I will help them if they need help, but on the other hand, I want them to tell me how they can solve their own problems.

If you don't have that, you can't expect an organization that will function properly.

Chairman ROCKEFELLER. But if field managers really feel that you are looking hard at what they are doing and that they might have to report to you any given night on something that is happening, it would send a message to every one of them. That would have a heck of an effect as well as the face-to-face meetings and letters.

Mr. COOPER. I think that has to be the approach that, if confirmed, I will take.

Chairman ROCKEFELLER. Yes. Good.

Dr. Roswell, let me say something politely, but I need to say it firmly: Some of your pre-hearing questions and answers were a little bit what I would call "general" or lacking in specificity. I understand that because if I were in your position, and I was replying to a Senate Committee on Veterans' Affairs, I would tell myself I am going to do this really well. I might not in the end, but I should aim that way and you should.

So, you described your vision for the VA health care system in the year 2006 in fairly general terms; too general for me. So, I would like to get a little bit more detail about what gets emphasized, what are your priorities, the size of the system, and your realistic projections as to what budget possibilities might do to your vision.

Dr. ROSWELL. Thank you, Mr. Chairman. I apologize for the vagueness in the answer. I believe that VA exists and must exist to meet the specialized needs of veterans. I don't believe America's veterans, whether today, tomorrow or 100 years from now will ever have the health care they deserve, not will it be provided in a comprehensive fashion if we don't have a dedicated system that is structured to meet the specialized needs, disabilities and problems associated with military service.

There are classic examples that abound. VA's world class spinal cord injury care, VA's blind rehabilitation care, VA's commitment to treating veterans with Post Traumatic Stress Disorder and other serious mental illness, those are the components of VA health care that we must safeguard because that is not care that can ever be vouchered or ever be provided in a system that is not specifically dedicated to veterans.

Having said that, we need to make the system more efficient. First of all, we need to preserve the quality that Ken Kizer and Tom Garthwaite have given us. We need to safeguard that. But we need to improve the efficiency with which we manage the system, the efficiency with which we manage both appropriated and non-appropriated revenues.

Having done that, we need to seek guidance from the committee on exactly what the mission of VA will be for long-term care of veterans.

I have very strong personal feelings. I have shared those briefly with you. I believe that we do have a tremendous commitment to meet the long-term care and end of life needs of World War II and Korean era veterans. Those have been our loyal customers for the last 50 years. They have been our primary users. They have stood by us during difficult times.

It would be a travesty, a national disgrace, to turn our backs on them right now. But to be able to meet those long-term care needs in a way that is consistent with our budget has to be done so that we don't irrevocably commit resources to a health care that is ill suited for veterans who will come behind them.

That is why I believe that long-term care is something that needs to be addressed in non-institutional settings. That is not to say I don't believe in a floor on nursing home beds. We do have to establish a floor. We need that capacity.

But I believe we can do a lot more in long-term care and end of life care by providing that care in non-institutional settings which provide greater functional independence to the veteran, a better quality of life, greater emotional support, not to mention lower cost, which is important.

Having said that, I think that——

Chairman ROCKEFELLER. May I interrupt on that, though?

Dr. ROSWELL. Certainly.

Chairman ROCKEFELLER. I would have a different point of view, and maybe this is just where I come from. I am a great believer in getting your, what is the phrase, your nose under the tent. I am now referring to long-term care.

If I start long-term care, we should be so lucky to get OMB and everybody to agree on regulations; it has only been 3 years, I wouldn't ask the question of affordability.

My reaction would be, instead, we are instead going to solve the problem and let the Congress and the President stew in the public and veteran's rage. Long-term care is the one thing, which we all face and which this country has done nothing about since Medicaid in the 60's—except what we did here in this committee nearly 3 years ago for a limited number of people.

So, argue with me for a second, if you care to. I would say, let's push the envelope and make the process catch up with us. Say, we will serve the veterans, because that is my job. That is what I took an oath for. Let the others figure out how I am going to get the funding as opposed to you becoming the budget officer for the VA.

I understand that is an easy thing for me to say.

Dr. ROSWELL. Mr. Chairman, I do agree with you. Let me clarify my point. My point is that before we push the envelope, before we build a better mousetrap for long-term care, and I believe VA can and will set the standard for the Nation in providing long-term care and end of life care. I deeply believe we can do that.

But before we push the envelope and create care delivery models that set the standard for the nation, not to mention the standard for veterans' health care, we must be as efficient as we possibly can with the taxpayer dollars.

So, all I am saying is that we have to maximize the efficiency of the appropriated resource, use it as wisely as we can, be the steward for America's taxpayers who have vested their dollars in us to provide care to America's veterans.

Having done that though, you are absolutely correct, I do agree with you that we should begin to explore innovation in long-term care. For example, I believe that we have a pilot in Florida that will provide quite comprehensive long-term care at very little cost from the medical care appropriation.

Using VA's enhanced use leasing capability, we can make property available. We can bring in an assisted living facility provider who will bear the cost of capital construction to build an assisted living facility. That ALF provider in Florida can accept Medicaid block waivers from the State. That coupled with the aid and attendance veterans are already receiving, is sufficient to pay the cost of care in an assisted living facility.

Now, you will argue, and rightly so, that an assisted living facility doesn't provide the same comprehensive level of care as nursing home care, and that is correct. But by placing interactive technologies in an assisted living facility, as we have already done in Florida, we can provide telemedicine are to individuals in that situation. We can have an advanced practice nurse monitoring patients on a daily or even twice daily basis if needed.

When medical problems develop, when a need for hospitalization is identified, we can provide that care on a near immediate basis. We can even do that by co-locating such facilities next to VA outpatient clinics so that the trip to the doctor is minimal or non-existent, if VA physicians make house calls.

That is an example of how we can address long-term care needs and do it efficiently. We are talking pennies a day for care like that, versus hundreds of dollars a day in a staffed institution.

Chairman ROCKEFELLER. So, I can eliminate from my head and from the record any sense that you will judge what you can do in terms of consequences of demand.

The driving thing in you is to take care of the needs of as many veterans as we possibly can.

Dr. ROSWELL. As you well know, that is the purview of the authorizers and the appropriators to determine that.

Chairman ROCKEFELLER. No, no, it is, but then it gets inside the VA and then it takes on a whole life of its own.

Dr. ROSWELL. Mr. Chairman, as I said, I feel very strongly that we have to provide that care. I am excited about the opportunity to develop innovative long-term care models within the VA. I believe we can do that. I believe that the creation of such models will include institutional care but will also rely heavily on non-institutional care, and will create a comprehensive continuum of long-term care services that America's veterans will want, and I hope that we will be able to provide that.

Chairman ROCKEFELLER. I want you to talk about Roswell, not about Kizer and Garthwaite. I don't want you referring to the past. I want you referring to you and the future,

That is not commenting on either of them, but that was a different era. Everything is different, and we have not even talked—

and I am not going to this afternoon—in terms of preparing the VA hospitals to meet homeland security needs and all the rest of that.

I am not interested in Kizer or Garthwaite. I am interested only in Roswell and what you want to do in veterans' health care. So that the maintenance of what has been done is not a phrase I welcome.

Do I make my point?

Dr. ROSWELL. Yes, Mr. Chairman, you do.

Chairman ROCKEFELLER. Mr. Cooper, how has the implementation of the task force recommendations been different than you expected and are you facing barriers or time constraints that you did not expect?

Mr. COOPER. I would say the implementation, as I have seen it, is not different from what I expected, other than the fact that I think it has been implemented a little bit faster than I might have expected.

I would further say to you that one of the things when we came in to start our report, I asked to see all the previous reports that had been done over the previous decade to tell how to do it better in VBA. There are about five of them including National Academy of Public Administration [NAPA], Mr. Melidosian's report, and a couple of others.

I then asked to see the specific steps that were taken to carry out those recommendations and they were not very complete. A lot of things had not been done. I would say to you that this report is being executed in about the best manner I have ever seen a report executed in that it is being followed very closely. There are about, I believe right now, maybe seven of those 34 recommendations that they consider done.

The others are ongoing and will take varying amounts of time. So, my answer to you is that the execution of this report is much more thorough and more carefully followed and more fully reported than what I observed had been done in previous administrations or in previous times when they had received reports.

I would say to you that the two gentlemen who have been in charge for the last 4 months, Judge McMichael and Stan Sinclair, both of whom were on our Task Force study, and very strong participants in it. I think it is fortuitous that they were able to go over because they fully agreed with the report and did everything they could to implement every facet that they could. For those recommendations they didn't want to do right that second or they thought not appropriate, they have started people looking at them very carefully to see how they will execute them.

I personally think they have done as good a job as anybody could do with a report like this. It is much easier to write a report than it is to execute it.

Chairman ROCKEFELLER. I think you are right on that.

Mr. COOPER. Thank you.

Chairman ROCKEFELLER. Dr. Roswell, back to you. This is not a question but an unburdening on my part. I just want to make it very clear for the record, that the research program at the VA is very, very dear to this particular chairman's heart and I suspect to many around the table, for a lot of reasons.

I think it is critically important to veterans and to the system which serves veterans. I see the goal of the VA's research program as providing the best possible care for veterans.

I think the figure is still 50 percent of doctors-in-training rotate through VA hospitals, but on the other hand, the VA Hospital affiliated with Northwestern will be closed. I think above all, however, and the thing which attracts the best doctors is research.

I just think research helps to meet so many goals by being a potent attraction to the best possible folks in medicine that we possibly can. It also cements affiliations with universities, which is equally as important.

Along those lines, I think it is absolutely essential that researchers have the protected time to do their research. I want to make sure that they do, because if you are a researcher who is not allowed to do research but is required to do other things, people are going to find out about it. It won't take long for the word to get around.

So, the protected time factor is very, very important to me. Of course, it increases expense. But I think in the long run, it is enormously cost effective. So, I am going to be looking to you, Dr. Roswell, to make all of this happen.

I have no worries, do I?

Dr. ROSWELL. Mr. Chairman, I would like to state for the record that I began my VA career some 20 years ago as a direct result of VA's research program. I came to the VA as a young staff physician seeking research funding through the VA. That is how I began my research career and my VA career.

I am in total agreement with your commitment to research. It not only adds value, it improves the care that we provide to today's veterans, to tomorrow's veterans, and we really do need to safeguard that program, build that program in such a way that it continues to make VA health care second to none.

I think that protected time is important. I think the way we distribute money through the VERA model is important. I think the way we utilize nonprofit research corporations to augment and bolster the care we provide through our programs is very important.

You can count on me to work with you to see those goals accomplished.

Chairman ROCKEFELLER. Another question, Dr. Roswell, you indicated in your pre-hearing questions that quality management activities will be one of your highest priorities. This is very key for me, too. If not now, could you provide this committee with a plan, and this gets back to the broadness of your pre-hearing questions, describing exactly what you will do to make sure quality improvement is not merely a paper exercise. I ask that you do that within the next 30 days.

Mr. Cooper, a final question for you: The task force reviewed many of the previous reports and studies conducted on the VA, as you would expect. It concurs with many of the recommended changes from those reports.

But I believe that some of the VBA actions actually exacerbated the backlog because of too many and too disparate initiatives. That is an interesting thing to say. On the one hand, you have to do different things to innovate, if the changes get too complicated or so

innovative you may confuse or overwhelm people. These two visions are difficult to reconcile.

In some ways you may end up making the process more inefficient.

What is your view about that?

Mr. COOPER. What you say is absolutely correct in that you don't want to put in change on top of change on top of change. It is all part of getting focused as to what you think is the right way to do it. Although there may be four or five rights ways to do it, once you decide on the right way you are going, then that is what you have to do. So, you can't allow changes to come in from the side just to change.

We felt as we looked at changes that have been made, particularly in the last 4 years, that they had not been implemented in a way that you saw how one change affected the other changes.

Further, we felt that each one of the 57 different RO's were taking parts of those changes and implementing them to the degree that they wanted to or did not want to. Some they limited to 5 percent. In some, a few ran off and did it 100 percent. But there was such a wide disparity in the way those were implemented that it was difficult to figure out exactly who was where and why things were not going well.

As I mentioned earlier, we did look at each one of those previous reports. We did use those as we developed our own recommendations. Now the point is to make sure that we do not implement all 34 recommendations simultaneously and we very carefully stated that.

We put about 20 of those recommendations in a short-term timeframe. However you are not going to do all 20 in that short term. We are merely saying that any one of those, or four or five of those could be done in the first 6 months. But for pity sakes, you don't want to do all of them at once over the first 6-month period.

We tried to remain very cognizant of that. I would say to you that the implementation process that they are going through very carefully takes that into account. It looks to see where they are today, where they want to get, and then how that is impacted with other recommendations.

So, again, I would say to you, I think the execution and implementation of this report, one, is very vital, but two, right now is being done as well as I could possibly imagine.

Chairman ROCKEFELLER. OK. I would just conclude by saying that I would suspect that, if the veterans of the United States were looking in on this, they would look upon you two as the hope of the VA.

I am not putting the Secretary down because he is the top person.

This confirmation process is very, very important to me, and I think very meaningful to the VA and its future.

So, there is a lot riding on you two gentlemen. I am going to support you both, and I think the committee is going to move expeditiously to make sure that you get into your positions as quickly as possible. But I just can't emphasize how important I think the work each of you will undertake.

So, I thank you both very much for coming. I look forward to working with you both in the future.

Mr. COOPER. Thank you, Mr. Chairman.

Dr. ROSWELL. Thank you.

Chairman ROCKEFELLER. The committee is recessed.

[Whereupon, at 3:59 p.m., the committee was adjourned.]

# APPENDIX

PREPARED STATEMENT OF HON. ARLEN SPECTER, U.S. SENATOR FROM PENNSYLVANIA

Thank you, Mr. Chairman. I join you in welcoming Admiral Cooper and Dr. Roswell.

I also welcome the family members of both nominees. I know it is a proud day for both the Roswell and Cooper families; both families should be proud of the long and distinguished service that each nominee has already given to the Nation. In my estimation, VA is fortunate—very fortunate—that the President has asked these two fine men to serve. And I am pleased to consider their nominations. I look forward to hearing their testimony.

These are tough jobs that Dr. Roswell and Admiral Cooper propose to take on. Indeed, I think they are two of the most difficult—and important—jobs in government. The Under Secretary for Health is in charge of the Nation's largest integrated health system—a system that provides care to over 4 million veterans and which employs almost 200,000 people. The Under Secretary for Benefits is charged with administering over $30 billion per year in compensation, rehabilitation and readjustment benefits received by over 3 million veterans. Both of these jobs—obviously—are big jobs. I do admire both of you for stepping up to take on the challenges these jobs entail.

Admiral Cooper, Secretary Principi told me before he was confirmed that his number 1 priority would be speeding and streamlining VA's claims adjudication system. The Secretary has, in effect, staked his reputation on solving the seemingly intractable problems that have plagued VA's adjudication system; he has now, in effect, placed his reputation in your hands. Since your hands have guided an anti-ballistic missile-equipped nuclear submarine, no one can question whether they are steady enough. But it is a considerable challenge you propose to take on, Admiral Cooper. I look forward to questioning you today—and over the course of the next four years—on how VA claims processing can be speeded and, simultaneously, improved from a quality standpoint.

Doctor Roswell, you may have been informed that while the Chairman and I are strong supporters of needed VA funding, I have made the point to the Secretary that VA has to do better in billing for—and collecting—reimbursements owed to VA by insurance companies for VA treatment of veterans' non-service-connected illnesses and injuries. I am pleased to learn that the service network that you have headed up since 1995 is the VA's single most successful collector of insurance reimbursements. That is good news indeed since what you have done in Florida needs to be brought to the rest of the VA system. You can count on the Chairman and me to be among your strongest proponents in the annual budget fights up here on Capitol Hill. But we will both insist that VA do better in generating a small fraction of its operating funds through collections.

One other matter needs to be discussed briefly this morning. I am told that VA has grown uneasy with Congressional mandates with respect to long term care and other forms of priority care at VA. I want to make two points with utter clarity: statutory mandates are mandates. VA does not have the discretion to "do what it can" to meet statutory mandates—it must meet them. And as for the substance of such mandates, I want to make clear my commitment to a VA that provides inpatient-based long term care, and non-institutional long term care services, to senior veterans in Pennsylvania—and nationally. Such services are, in my estimation, among the most important services that VA provides to veterans. If you want to gain—and keep—my support, Dr. Roswell, you will need to share that commitment to our seniors' needs. Since you have spend the last six years operating VA's medical care system in Florida, I believe you have been sensitized to those needs. Please understand that they are important in other States too.

As I said at the outset, I welcome both of you. I look forward to working with each of you for a long time.

PREPARED STATEMENT OF HON. BEN NIGHTHORSE CAMPBELL, U.S. SENATOR FROM COLORADO

Thank you, Mr. Chairman. I appreciate your convening today's hearing which will give us the opportunity to hear testimony from Robert H. Roswell, nominee to be Under Secretary of Health, and Daniel L. Cooper, nominee to be Under Secretary for Benefits. I welcome both witnesses and look forward to their testimony.

I have always supported the VA's efforts to do the absolute best they can with the money they are provided. This year, however, I am concerned that the VA health care system is not currently able to meet the needs of our veterans. Many veterans in Colorado are required to travel long distances for routine care, and others are required to wait months for appointments for routine check-ups. We have an obligation to help our vets get the care they need and deserve.

And, I am supportive of the innovative proposal in Colorado to relocate the Denver Veterans Affairs Medical Center (DVAMC) to the site of the former Fitzsimons Army Medical Center. I believe the relocation can provide state of the art health care facilities for Colorado veterans and veterans nation-wide. I look forward to hearing Dr. Roswell's thoughts on addressing these issues.

In addition, I remain concerned about the continued backlog that continues to hinder the adjudication process of veterans' claims appeals. I understand some progress has been made in this area. And, I understand that Admiral Cooper has extensive experience and some innovative ideas for addressing the problem. I look forward to his strategies for eliminating the backlog and speeding up the process.

Again, Mr. Chairman, thank you for convening this hearing. I look forward to the testimony.

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PREPARED STATEMENT OF HON. LARRY E. CRAIG, U.S. SENATOR FROM IDAHO

Mr. Chairman, it is indeed a pleasure to be here at the confirmation of Dr. Robert H. Roswell for Under Secretary for Health, and Admiral Daniel L. Cooper for Under Secretary for Benefits. The mission of the VA is not only high quality health care, but it also encompasses educational and housing loans, pensions, and survivors benefits. Thus, it is imperative for us as custodians of the public's trust to ensure that those individuals that lead this organization are worthy of that high calling.

After reviewing the qualifications of the two nominees I can say that I am impressed with both of them. Dr Roswell's background as a VA physician, and former director of Veterans Integrated Service Network (VISN) 8 indicates to me that he understands the intricacies of managing a large and diverse workforce and patient base, which is a necessity for an Administration that covers more than 170 medical centers across the country.

Admiral Cooper, who has served our great nation for 33 years in the Navy's Nuclear Submarine service, has first hand knowledge of what the VA is and understands the potential of what the VA can be. It is also important to note that he has worked with VA Secretary Principi previously and has his trust, as he was appointed to head the VA Claims Processing Task Force. I think it only proper that he now have the opportunity to implement the recommendations his task force has previously issued.

I look forward to working with both of these capable and astute administrators when addressing, expanding, and improving the delivery of services and benefits so that all veterans have equal access to high quality medical care. In many areas of the country as in Idaho, the waiting lists are long and only getting longer. I would encourage the VA to continue exploring under serviced areas. Any time we can provide local—as opposed to regional—service, the veterans will be grateful and overall cost reduced. Of course, one of my major concerns is ensuring funding for primary care is adequate, but we must not forget to provide all the services and specialty care that many of our veterans require.

I believe that Dr. Roswell and Admiral Cooper are both excellent choices to help define our commitment to our nation's veterans, while recognizing the tough fiscal decisions that must be made. Let us never forget the important role that our veterans have made insuring our national security—the United States is a super power and enjoys success because of the service and—as we have seen recently—the sacrifices of our veterans, for whom we should be forever grateful.